

Erin T. Carey, M.D.

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IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
CHARLESTON DIVISION

IN RE: ETHICON, INC.
PELVIC REPAIR SYSTEM
PRODUCTS LIABILITY LITIGATION

THIS DOCUMENT RELATES TO:
JO HUSKEY and ALLEN HUSKEY,

MDL NO. 2327
Master File No.
2:12-MD-02327
JOSEPH R. GOODWIN
U.S. DISTRICT JUDGE

Plaintiffs,

vs.

ETHICON, INC., et al.,

Case No.
2:12-MD-05201

Defendants.

DEPOSITION OF ERIN T. CAREY, M.D.,

produced, sworn and examined on behalf of the Defendants pursuant to Notice, on Wednesday, the 2nd day of July, 2014, between the hours of 9:04 a.m. and 2:46 p.m. of that day, at the law offices of Wagstaff & Cartmell, 4740 Grand Avenue, Suite 300, in the City of Kansas City, in the County of Jackson, and the State of Missouri, before me, NAOLA C. VAUGHN, MO CCR 1052, KS CCR 0895, CRR, RPR, a Certified Court Reporter, within and for the States of Missouri and Kansas.

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<p>1 down there for your revision?</p> <p>2 A. Revised July 2014.</p> <p>3 Q. Okay. So we're marking as Exhibit 3</p> <p>4 your revised curriculum vitae, revised as of</p> <p>5 July 2014; correct?</p> <p>6 A. Correct.</p> <p>7 Q. And is this your current CV, meaning</p> <p>8 it's up to date on all your publications, your</p> <p>9 submissions, things of that nature?</p> <p>10 A. Correct.</p> <p>11 Q. Do you have an extra copy of your</p> <p>12 updated CV for you to look at?</p> <p>13 A. I have it -- no. I don't. That's my</p> <p>14 only copy.</p> <p>15 MR. KUNTZ: I can get you another copy.</p> <p>16 Q. BY MR. SNELL: Is Exhibit 3, your</p> <p>17 July 2014 curriculum vitae, accurate?</p> <p>18 A. To the best of my knowledge, yes.</p> <p>19 Q. As I understand it, you did a residency</p> <p>20 in obstetrics and gynecology?</p> <p>21 A. Yes.</p> <p>22 Q. And where was that at?</p> <p>23 A. At the Mayo Clinic.</p> <p>24 Q. You then did an advanced laparoscopy and</p> <p>25 pelvic pain fellowship at the University of North</p>	<p>1 slings polypropylene slings?</p> <p>2 A. They were.</p> <p>3 Q. Were they the original TVT retropubic</p> <p>4 slings?</p> <p>5 A. They were the Align product, I believe.</p> <p>6 Q. Do you know who made the Align product?</p> <p>7 A. I believe it's Boston Scientific.</p> <p>8 Q. Did you actually pass the instruments</p> <p>9 during those procedures?</p> <p>10 A. I did.</p> <p>11 Q. On how many occasions did you do the</p> <p>12 transvaginal retropubic slings?</p> <p>13 A. During my residency?</p> <p>14 Q. Um-hum.</p> <p>15 A. 25 to 30.</p> <p>16 Q. Have you continue to do slings?</p> <p>17 A. I have not.</p> <p>18 Q. Would it be correct that you have done</p> <p>19 25 to 30 transvaginal retropubic slings in your</p> <p>20 career?</p> <p>21 A. Yes.</p> <p>22 Q. How many transvaginal transobturator</p> <p>23 slings have you done in your career?</p> <p>24 A. Only a handful. I mean, less than 5.</p> <p>25 Probably 5.</p>
<p>1 Carolina?</p> <p>2 A. Yes.</p> <p>3 Q. When you did your obstetrics and</p> <p>4 gynecology residency, did you do any prolapse or</p> <p>5 incontinence surgery?</p> <p>6 A. I did.</p> <p>7 Q. Which ones?</p> <p>8 A. We did traditional anterior and</p> <p>9 posterior repairs, as well as transvaginal</p> <p>10 retropubic slings and transobturator slings. We</p> <p>11 also performed the Burch procedure.</p> <p>12 Q. Who was it that taught you how to</p> <p>13 perform the Burch procedure?</p> <p>14 A. Dr. Stanhope. Stanhope,</p> <p>15 S-t-a-n-h-o-p-e.</p> <p>16 Q. Who taught you how to do the</p> <p>17 transvaginal retropubic slings?</p> <p>18 A. There was Dr. Klingele, Gebhart and</p> <p>19 Trabuco.</p> <p>20 Q. Did those same physicians teach you how</p> <p>21 to perform the transvaginal transobturator sling?</p> <p>22 A. Dr. Trabuco did that for a period of</p> <p>23 time, to my recollection. I think he was the only</p> <p>24 one who tried it.</p> <p>25 Q. Were those transvaginal retropubic</p>	<p>1 Q. Were any of those transvaginal</p> <p>2 transobturator slings the TVT-O?</p> <p>3 A. No.</p> <p>4 Q. Do you know which brand they were?</p> <p>5 A. They were the Monarch.</p> <p>6 Q. So the transvaginal transobturator</p> <p>7 slings that you would have learned under Trabuco</p> <p>8 would have been the Monarch sling?</p> <p>9 A. Yes.</p> <p>10 Q. And that's an outside end sling?</p> <p>11 A. Correct.</p> <p>12 Q. When you started doing the Align</p> <p>13 transvaginal retropubic sling, did you investigate</p> <p>14 whether there were any randomized control trials for</p> <p>15 that product?</p> <p>16 A. As part of our residency, we were aware</p> <p>17 of some of the randomized control trials for the</p> <p>18 TVT.</p> <p>19 Q. My question is specific to the Align.</p> <p>20 So you used the Align transvaginal</p> <p>21 retropubic sling?</p> <p>22 A. Yes. Um-hum.</p> <p>23 Q. And did you research and determine</p> <p>24 whether there were randomized control trials on that</p> <p>25 particular sling at the time you began using it?</p>

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<p style="text-align: center;">Page 10</p> <p>1 A. I read many RCTs on the transvaginal 2 sling. So I'm sure that some of them had the Align 3 product.</p> <p>4 Q. Okay.</p> <p>5 A. This was during our urogynecology 6 rotation. And so that was a part of our education.</p> <p>7 Q. How long was your urogynecology 8 rotation?</p> <p>9 A. I spent a total of six months with 10 urogynecologists.</p> <p>11 Q. Had you done other rotations before that 12 during your residency?</p> <p>13 A. Our GYN surgery rotations were divided 14 between GYN oncology --</p> <p>15 Q. Oncology?</p> <p>16 A. Uh-huh. Oncology. And urogynecology 17 and then three months minimally invasive surgery.</p> <p>18 Q. When you say three months minimally 19 invasive surgery, what types of surgeries are you 20 talking about?</p> <p>21 A. That's going to be the laparoscopic 22 procedures, such as excision of endometriosis, 23 ovarian cystectomies, bilateral 24 salphingo-ophorectomies, lysis of adhesions.</p> <p>25 Q. Did you do robotic surgery during your</p>	<p style="text-align: center;">Page 12</p> <p>1 your team to draft these manuscripts for your 2 papers?</p> <p>3 A. I mean, again, it depends on what the 4 project consists of. If you're starting from, I 5 think, a questionnaire and you have to actually send 6 a questionnaire out and wait for it to be returned, 7 I mean, that could take 6 to 12 months. But if 8 you -- if it's more of an opinion paper, 3 to 9 6 weeks. It depends on the -- the type of research 10 paper that you're writing.</p> <p>11 Q. So depending upon the type of research 12 paper you're writing, it would take between 3 weeks 13 and even up to 12 months?</p> <p>14 A. And sometimes longer, depending on the 15 group you're working with, if you're waiting for 16 someone to get a draft back to you. I mean, a lot 17 of that is just waiting for people to respond. I 18 think the one paper might actually be missing from 19 my CV.</p> <p>20 Yeah, the most recent publication 21 actually is not on here.</p> <p>22 Q. And what would that be?</p> <p>23 A. That is the post-hysterectomy 24 dyspareunia paper, with my colleagues from 25 North Carolina.</p>
<p style="text-align: center;">Page 11</p> <p>1 GYN training?</p> <p>2 A. I did.</p> <p>3 Q. What types?</p> <p>4 A. In residency we received training of the 5 daVinci robot during both of our urogynecology and 6 oncology rotations. You performed hysterectomies, 7 myomectomies, sacrocolpopexy. And then I went on to 8 do the two-year fellowship in minimally invasive 9 surgery, where I learned laparoscopic 10 hysterectomies, laparoscopic myomectomies, advanced 11 endometriosis surgery, and continued robotic 12 training.</p> <p>13 Q. Some of your publications were from the 14 time of your fellowship; is that correct?</p> <p>15 A. Correct.</p> <p>16 Q. And what was your involvement in those 17 publications?</p> <p>18 A. As far as?</p> <p>19 Q. What was your role? Were you a part of 20 the original research team?</p> <p>21 A. It depends on the publication. So some 22 of them I was the coinvestigator. Anyone who's 23 listed as an author has made a substantial 24 contribution to at least the body of the paper.</p> <p>25 Q. How long will it typically take you and</p>	<p style="text-align: center;">Page 13</p> <p>1 Q. Is that a -- has it been published?</p> <p>2 A. It has, yeah. Yes. This spring.</p> <p>3 Q. What journal?</p> <p>4 A. Journal of Minimally Invasive 5 Gynecology. It was an invited topic for us to 6 discuss.</p> <p>7 Q. Okay. How long did it take you -- what 8 type of paper was that? Was it like -- sounds like 9 a review.</p> <p>10 A. A review.</p> <p>11 Q. How long did it take you to draft and 12 finalize and submit that review?</p> <p>13 A. I would be guessing.</p> <p>14 Q. Well, give me your best estimate.</p> <p>15 A. You mean between the group of us?</p> <p>16 Q. Yes.</p> <p>17 A. Probably coordinating 6 to 7 authors, 18 probably 8 to 12 weeks to get a final draft.</p> <p>19 Q. And you didn't have to do any original 20 research, such as going and looking at patient 21 charts for this paper, I take it?</p> <p>22 A. Correct. Correct.</p> <p>23 Q. So even a review article, it doesn't 24 have to go back and look at original charts and 25 things of that nature, it can take up to 8 weeks or</p>

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<p>1 more for finalization to submit?</p> <p>2 A. Between a group of busy clinicians with</p> <p>3 limited research time, absolutely. Very common.</p> <p>4 Q. And are all of the authors on this</p> <p>5 post-hysterectomy dyspareunia paper people who made</p> <p>6 substantial contributions to the paper, as you</p> <p>7 earlier testified to?</p> <p>8 A. They're all part of my research team.</p> <p>9 Q. Who came up with the idea to do the</p> <p>10 post-hysterectomy dyspareunia paper?</p> <p>11 A. I believe it was an invited topic from</p> <p>12 the Journal of Minimally Invasive Gynecology.</p> <p>13 Q. Was Dr. Steege an author on that paper?</p> <p>14 A. I believe he was the senior author on</p> <p>15 the paper.</p> <p>16 Q. What was his role in that paper?</p> <p>17 A. He coordinated the topics between the</p> <p>18 fellows and graduates. He had the final review of</p> <p>19 the paper in submission. And he also worked on the</p> <p>20 introduction. And I don't know the specific</p> <p>21 components of the topics that he provided.</p> <p>22 Q. Other than the post-hysterectomy</p> <p>23 dyspareunia paper published in the Journal of</p> <p>24 Minimally Invasive Gynecology this year --</p> <p>25 A. Um-hum.</p>	<p>1 performed in your career?</p> <p>2 A. I have participated in -- I estimate 20.</p> <p>3 I do not perform them now.</p> <p>4 Q. Okay. And what type of material did</p> <p>5 those sacrocolpopexies use to support the vaginal</p> <p>6 vault?</p> <p>7 A. Mesh.</p> <p>8 Q. Polypropylene mesh?</p> <p>9 A. Polypropylene mesh.</p> <p>10 Q. Do you know which brand?</p> <p>11 A. I do not.</p> <p>12 Q. Do you know the pore size of that mesh?</p> <p>13 A. I do not.</p> <p>14 Q. Was it monofilament or multifilament</p> <p>15 polypropylene mesh?</p> <p>16 A. I believe it was monofilament.</p> <p>17 Q. When you were doing the transvaginal</p> <p>18 slings, did you know what the pore size to those</p> <p>19 meshes was?</p> <p>20 A. I do not.</p> <p>21 Q. Were they monofilament polypropylene</p> <p>22 meshes to your recollection?</p> <p>23 A. They were.</p> <p>24 Q. You testified about the surgeries you</p> <p>25 performed in your fellowship, the laparoscopic</p>
<p style="text-align: center;">Page 15</p> <p>1 Q. -- other than that, everything else on</p> <p>2 the CV is up to date?</p> <p>3 A. It should be, yes.</p> <p>4 Q. You testified earlier you've done</p> <p>5 anterior and posterior repairs for prolapse. I take</p> <p>6 it those would be colporrhaphy?</p> <p>7 A. Correct.</p> <p>8 Q. You've also done sacrocolpopexy?</p> <p>9 A. Correct.</p> <p>10 Q. Have you done any other procedures for</p> <p>11 prolapse?</p> <p>12 A. No. I do perform what are called</p> <p>13 colpoplasties at the time of a laparoscopic</p> <p>14 hysterectomy or vaginal hysterectomy.</p> <p>15 Q. When did you first learn to do the</p> <p>16 sacrocolpopexy?</p> <p>17 A. It was part of our curriculum in</p> <p>18 residency.</p> <p>19 Q. Do you remember who taught you to do the</p> <p>20 sacrocolpopexy?</p> <p>21 A. The urogynecologists' names I provided</p> <p>22 earlier.</p> <p>23 Q. Klingele, Gebhart and Dr. Trabuco.</p> <p>24 A. Right.</p> <p>25 Q. How many sacrocolpopexies have you</p>	<p style="text-align: center;">Page 17</p> <p>1 hysterectomy, myomectomy, advanced endometriosis</p> <p>2 surgery.</p> <p>3 A. Um-hum.</p> <p>4 Q. And you continue your robotic training</p> <p>5 as well; is that correct?</p> <p>6 A. Correct.</p> <p>7 Q. Is that a full list of the surgeries you</p> <p>8 performed during your fellowship?</p> <p>9 A. No, it is not.</p> <p>10 Q. Can you give me the rest of them,</p> <p>11 please?</p> <p>12 A. In addition, in both residency and</p> <p>13 fellowship, we performed mesh excision.</p> <p>14 Q. Okay. Any others?</p> <p>15 A. We performed appendectomies,</p> <p>16 ureterolysis, enterolysis, cystoscopies with</p> <p>17 hydrodistention. I also performed neuromodulation</p> <p>18 procedures, including the use of the InterStim</p> <p>19 device.</p> <p>20 In my additional training with pain and</p> <p>21 anesthesia, I also learned nerve block technique</p> <p>22 with both ultrasound guidance, fluoroscopic</p> <p>23 guidance, and nerve stimulator guidance.</p> <p>24 Q. Is that different than nerve blocks,</p> <p>25 nerve stimulator guidance?</p>

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<p style="text-align: center;">Page 18</p> <p>1 A. You can do nerve blocks blind, but you 2 can also use them with the nerve stimulator or via 3 the other image-guided techniques. It depends on 4 the nerve. 5 Q. Okay. When you say you can do nerve 6 blocks blind, what do you mean by that? 7 A. Use anatomic landmarks. There's some 8 nerves that have very little anatomical variance 9 between patients. And people with normal anatomy 10 you're able to perform injections without 11 image-guided devices. 12 Q. Which nerves are there very little 13 anatomic differentiation between patients? 14 A. I mean, it depends. I mean, there's -- 15 the other thing is that, when you do perform a nerve 16 block, you are also injecting a large volume of 17 anesthetic that will have a wide area of 18 distribution. So even if you're not in the exact 19 location of the nerve, you will likely be able to 20 provide an appropriate block, if you are within 21 several centimeters. So it depends on the nerve. 22 Q. Well, I think my question was: You 23 mentioned it's done where nerves -- it's done on 24 nerves with very little anatomic variation between 25 patients.</p>	<p style="text-align: center;">Page 20</p> <p>1 you done in your career? 2 A. I would estimate 20 to 30. 3 Q. Do you have any idea as to the breakdown 4 of those excision surgeries, whether a certain 5 percent or number were from prolapse mesh like 6 sacrocolpopexy or transvaginal mesh as compared to 7 slings? 8 A. I notice in my -- in my residency, we 9 removed several of the large prolapse kits, device 10 kits, but in my fellowship we predominantly saw -- 11 we saw a combination of both the kits and the 12 slings. I have never removed mesh from a 13 sacrocolpopexy. 14 Q. Have you read literature that discusses 15 the mesh sometimes has to be removed from 16 sacrocolpopexy? 17 A. It sometimes does, but that is a much 18 less frequent occurrence. Also in my fellowship we 19 had a mesh pain clinic. So we saw a higher volume 20 of women who had mesh complications. But we did not 21 necessarily always remove the mesh. 22 Q. And you all weren't the ones putting in 23 the mesh in the first place? 24 A. Correct. Not in fellowship. 25 Q. So you didn't have any way of</p>
<p style="text-align: center;">Page 19</p> <p>1 So my question is: Which nerves have 2 very little anatomic differentiation between 3 patients? 4 MR. KUNTZ: Objection. 5 You can answer. 6 A. The nerves that we routinely will block 7 with anatomic guidance include nerves of the 8 abdominal wall. And this is the iliohypogastric and 9 ilioinguinal nerve. And while there is anatomic 10 variance, if you use the anterior, superior iliac 11 spine and you are able to feel the muscle layers 12 that you go through, you're able to effectively 13 block that nerve. 14 Q. BY MR. SNELL: Besides the abdominal 15 wall, are there any other nerves that are blocked in 16 a blind fashion? 17 A. I mean most nerves have some kind of 18 ability to be blocked in a blind fashion. Do I do 19 all of those? Not necessarily. In my practice, I 20 do the anterior abdominal wall. Occasionally I do 21 the terminal branches of the pudendal nerve as a 22 diagnostic technique in my practice. Occasionally I 23 will block the genitofemoral terminal branch as a 24 diagnostic technique blindly in my practice. 25 Q. How many mesh excision surgeries have</p>	<p style="text-align: center;">Page 21</p> <p>1 scientifically tracking the number of meshes put in 2 to compare that to the number of women who presented 3 to your clinic? 4 A. That's one of the big issues with this 5 entire, I mean, complaint is that these women are 6 not going back to the primary providers. Also we 7 were taking care of our urogynecologists 8 complications within our own North Carolina 9 practice. But at least what we have seen is that 10 most women -- we had the ability to have a tertiary 11 referral center and a high volume but were not going 12 back to their primary providers who placed the mesh. 13 Q. The urogynecologists there at the 14 University of North Carolina, do you know what type 15 of slings they used? 16 A. I don't recall. 17 Q. So you don't know whether they would 18 have used a TVT retropubic or an Align or some other 19 retropubic sling? 20 A. I could find out, but I don't recall. 21 Q. What about transobturator slings for the 22 urogynecologist at UNC? Any idea what type of 23 slings they used? 24 A. I don't know. 25 Q. Some of the mesh revision procedures --</p>

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<p style="text-align: center;">Page 22</p> <p>1 strike that.</p> <p>2 When you testified you had done 20 to 30</p> <p>3 mesh excision procedures --</p> <p>4 A. Yes.</p> <p>5 Q. -- is that the total number in your</p> <p>6 career?</p> <p>7 A. That's an estimate.</p> <p>8 Q. Okay.</p> <p>9 A. But I've seen hundreds of women who have</p> <p>10 had mesh complications, including sexual pain,</p> <p>11 erosion and chronic pelvic pain from mesh. That did</p> <p>12 not mean I necessarily removed it.</p> <p>13 Q. Am I correct that of the 20 to 30 mesh</p> <p>14 excision procedures you've been involved in in your</p> <p>15 career, you can't say what number of them, if any,</p> <p>16 were TVT retropubic slings?</p> <p>17 And just so we're clear, when I say TVT</p> <p>18 retropubic, I mean my client's TVT retropubic</p> <p>19 slings.</p> <p>20 A. Oh, then I don't believe they -- I don't</p> <p>21 believe they have that product at Mayo.</p> <p>22 Q. And when you estimated you've removed --</p> <p>23 strike that.</p> <p>24 When you estimated you've done revision</p> <p>25 surgeries on 20 to 30 --</p>	<p style="text-align: center;">Page 24</p> <p>1 strike that.</p> <p>2 After your fellowship, where did you</p> <p>3 move then?</p> <p>4 A. Well, I stayed an additional -- after I</p> <p>5 finished my laparoscopic surgery and pelvic pain</p> <p>6 fellowship, I stayed an additional year at</p> <p>7 North Carolina.</p> <p>8 I was a GYN faculty, as well as pain</p> <p>9 anesthesia fellow, and worked closely with their</p> <p>10 team for GYN pain conditions. Once I completed my</p> <p>11 training there, I moved to Kansas City.</p> <p>12 Q. What's your current practice?</p> <p>13 A. I'm at the University of Kansas Medical</p> <p>14 Center, Center for Pelvic Pain and Sexual Health.</p> <p>15 Q. And when was it you moved to</p> <p>16 Kansas City?</p> <p>17 A. In July of 2013.</p> <p>18 Q. Since finishing your fellowship, have</p> <p>19 you done any surgeries?</p> <p>20 A. I have.</p> <p>21 Q. Which ones do you perform, following</p> <p>22 your -- strike that.</p> <p>23 So I'm only interested in now after your</p> <p>24 fellowship.</p> <p>25 A. Okay.</p>
<p style="text-align: center;">Page 23</p> <p>1 A. Um-hum.</p> <p>2 Q. -- meshes, am I correct that you can't</p> <p>3 testify that any of those were my client's,</p> <p>4 Ethicon's, TVT retropubic transobturator sling; is</p> <p>5 that correct?</p> <p>6 A. I'm sure I could go back in the medical</p> <p>7 record and find that information. We saw a variety</p> <p>8 of patients who have multiple different products of</p> <p>9 mesh. Do I know any of them was specifically the</p> <p>10 Ethicon product, I do not know.</p> <p>11 Q. So as you sit here today, you cannot</p> <p>12 testify under oath that you've removed a TVT</p> <p>13 retropubic transobturator sling made by Ethicon?</p> <p>14 A. I've taken care of patients who have had</p> <p>15 complications from --</p> <p>16 Q. Move to strike. This is -- I want to</p> <p>17 move this deposition along, and I'm asking very</p> <p>18 simple, straightforward questions. This is a yes or</p> <p>19 no answer. All right.</p> <p>20 As you sit here today, under oath, can</p> <p>21 you testify that you have removed an Ethicon TVT-O</p> <p>22 transobturator sling?</p> <p>23 A. Not to my knowledge.</p> <p>24 Q. Okay. After you finished your</p> <p>25 fellowship, did you move back here to -- well,</p>	<p style="text-align: center;">Page 25</p> <p>1 Q. For the types of surgeries you do at</p> <p>2 your practice when you were at UNC for that year,</p> <p>3 but also since you're here.</p> <p>4 A. I do the same surgeries.</p> <p>5 Q. Can you just give me the quick list?</p> <p>6 A. Sure.</p> <p>7 Q. Of the ones that you do.</p> <p>8 A. I perform laparoscopic hysterectomy,</p> <p>9 myomectomy, excision of endometriosis, excision of</p> <p>10 large pelvic masses, lysis of adhesions,</p> <p>11 appendectomies. I perform robotic myomectomies and</p> <p>12 hysterectomies. I -- what I did not mention</p> <p>13 previously, I also perform vulvar surgery. So I do</p> <p>14 some vestibulectomies. It's excision of the vulvar</p> <p>15 vestibule for pain. I also perform cystoscopy,</p> <p>16 cystoscopy with hydrodistention, neuromodulation</p> <p>17 procedures, and then a variety of blocks.</p> <p>18 Q. Okay. The vulvar surgery you perform --</p> <p>19 A. Um-hum.</p> <p>20 Q. -- what's the reason behind why that --</p> <p>21 I assume that that's a painful condition to the</p> <p>22 woman?</p> <p>23 A. It is.</p> <p>24 Q. Is that the reason why you perform the</p> <p>25 surgery?</p>

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<p>1 A. In some women who have what's called -- 2 the new term is provoked vestibulodynia. It used to 3 be known as vulval vestibulitis. So pain with 4 touching of the vulvar vestibule only.</p> <p>5 In the failed medical management, it is 6 reasonable to offer an excision of the vestibule 7 with vaginal advancement.</p> <p>8 Q. Do you do any cosmetic vaginal 9 surgeries?</p> <p>10 A. I do not. I have performed labioplasty 11 for labial hypertrophy. But I do not perform any 12 for cosmetic purposes or for -- or any of the 13 vaginal rejuvenation procedures.</p> <p>14 I also do chemodenervation of the 15 levator ani muscles. That's botulism toxin A. Of 16 some muscles of the pelvic floor for persistent 17 spasm and hypertonicity.</p> <p>18 Q. That's called Botox?</p> <p>19 A. Botox, yeah. I also do some 20 hysteroscopy, but not a lot of operative 21 hysteroscopy. I do diagnostic hysteroscopy.</p> <p>22 Q. Explain what that is.</p> <p>23 A. Where you look inside the uterus. You 24 do a dilation and curettage. And it's part of my 25 general gynecology practice. It's bread and butter</p>	<p>1 Q. So laparoscopy is basically laparoscopic 2 surgery?</p> <p>3 A. Yes.</p> <p>4 Q. I'm confused. I didn't know if it was 5 some type of special laparoscopic surgery.</p> <p>6 A. No. Just --</p> <p>7 Q. Myomectomy? What's that?</p> <p>8 A. Removal of uterine fibroids.</p> <p>9 Q. Okay. When you say advanced 10 endometriosis surgery --</p> <p>11 A. Um-hum.</p> <p>12 Q. -- what type of surgery are you talking 13 about there?</p> <p>14 A. Endometriosis is -- has many different 15 presentations. And I mean that in a way that it is 16 from a -- it's four different stages of disease. So 17 at the most -- I mean, at stage 4 disease would be 18 where you have retroperitoneal fibrosis of the 19 tissue, displacement of the ureters, adherence of 20 the uterus to the ovaries and bowel and bladder.</p> <p>21 Q. So would you do advanced endometriosis 22 surgery only on a stage 4 endometriosis patient?</p> <p>23 A. I guess I don't know what you're saying. 24 I mean, that would be considered an advanced 25 procedure. I perform excision of endometriosis on</p>
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<p>1 gynecology.</p> <p>2 Q. What is the -- strike that.</p> <p>3 Is laparoscopy the surgery that one can 4 do to diagnose endometriosis? Or is there some 5 other type of surgery? I might be butchering the 6 words.</p> <p>7 A. No. The only way to diagnose 8 endometriosis is a pathologic or histologic 9 evaluation of tissue sampled at the time of 10 laparoscopy or open procedure.</p> <p>11 Q. When you say the only way to diagnose 12 endometriosis is a pathologic or histologic 13 evaluation of tissue sampled at the time of 14 laparoscopy or open procedure, what do you mean by a 15 laparoscopy?</p> <p>16 A. Like what is a laparoscopy?</p> <p>17 Q. Yeah.</p> <p>18 A. Or laparoscopic surgery?</p> <p>19 Q. Okay.</p> <p>20 A. It is where you insufflate the abdomen 21 with carbon dioxide, and you place either one or 22 multiple instruments called trocars into the 23 abdomen, including a site for a camera, and then 24 evaluate the pelvic peritoneum and biopsy any tissue 25 that appears consistent with endometriosis.</p>	<p>1 all stages.</p> <p>2 Q. Okay.</p> <p>3 A. However, only certain providers have the 4 clinical skills to do advanced disease.</p> <p>5 Q. Why do you perform excision of 6 endometriosis in all stages?</p> <p>7 A. It can be for a variety of reasons.</p> <p>8 Q. What are those reasons?</p> <p>9 A. Fertility is one of them. You can have 10 a pelvic mass, called an endometrioma, which is an 11 endometriosis of an ovary which can become quite 12 large and uncomfortable. You can have small -- you 13 can have peritoneal implants that you can excise.</p> <p>14 Q. Peritoneal implants?</p> <p>15 A. Implants. Disease on the peritoneum or 16 uterus.</p> <p>17 Q. Not some type of implant put into the 18 body?</p> <p>19 A. No, no. Sorry. The disease itself on 20 the peritoneum, the bowel, the bladder, the 21 appendix.</p> <p>22 Q. Is pelvic pain a reason why you would do 23 endometriosis surgery?</p> <p>24 A. Yes. I think by that, I would mean 25 chronic pelvic pain of a reproductive aged woman who</p>

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<p style="text-align: center;">Page 30</p> <p>1 had significantly painful menses, I would offer her 2 a laparoscopy. If she failed medical management. 3 Q. When you do endometriosis surgery, do 4 you do it laparoscopically? 5 A. I do, yes. 6 Q. The neuromodulation procedures you 7 performed, you identified InterStim. 8 A. Yes. 9 Q. Any others? 10 A. No. 11 Q. What do you use InterStim for? 12 A. InterStim is basically neuromodulation 13 of the S3 nerve, and it's indicated for use of 14 urinary symptoms, such as urinary frequency, 15 urgency, incomplete emptying, urinary retention. 16 Q. How many InterStims have you placed? 17 A. Approximately -- I've trialed about 15, 18 and permanent placement, about 10. 19 Q. What's the failure rate of the 20 InterStim? 21 A. Would you clarify -- as far as the -- 22 because there's two -- it depends on what -- depends 23 on a couple of things. Depends on what you are -- 24 what you're considering failure. It also depends on 25 if you're talking about the trial or permanent</p>	<p style="text-align: center;">Page 32</p> <p>1 Q. And the medications and lifestyle are 2 the first line therapy? 3 A. They are. 4 Q. When you were describing how a 5 laparoscopy is done, you said that the abdomen is 6 insufflated with the carbon dioxide; correct? 7 A. Correct. 8 Q. What do you mean by the abandon is 9 insufflated? 10 A. You make a small incision usually in the 11 umbilicus and insert a device called a varus needle, 12 which is a closed technique. And you basically 13 place a needle into the abandon. And then once 14 you're past the peritoneum, you connect a tube of 15 gas that's CO₂, verify low opening pressures to make 16 sure that you're actually in the cavity and not in a 17 small space, and then fill the abdomen with air to 18 approximately 15 milliliters of mercury of pressure. 19 And then you place your instrument, your trocar. 20 Q. Where did you learn to perform 21 insufflation? 22 A. In residency. 23 Q. Is the varus needle the only needle or 24 instrument used to insufflate? 25 A. It's the one I use most often, but there</p>
<p style="text-align: center;">Page 31</p> <p>1 placement. 2 So one of the beauties of the device is 3 that you send someone home with a seven to ten-day 4 trial. I have my patients mark their urinary 5 symptoms as well as any pain symptoms that they 6 have. 7 And then I would say a trial that would 8 be considered positive enough to proceed with a 9 permanent implant would be greater than 50 percent 10 of those symptoms, improvement of greater than 11 50 percent of their symptoms. 12 Q. Okay. So the woman has symptoms of urge 13 incontinence, you do a seven to ten-day trial with 14 the InterStim. And you would consider it successful 15 such that you would offer permanent placement if the 16 woman has greater than 50 percent symptom resolution 17 of her urgency? 18 A. Only if they failed or could not 19 tolerate the medications or lifestyle modifications 20 for urgency incontinence and that she felt it was 21 beneficial to proceed with the device, we would 22 consider it. 23 Q. If there was a greater than 50 percent 24 symptom resolution? 25 A. Correct.</p>	<p style="text-align: center;">Page 33</p> <p>1 are multiple different techniques. One of them is a 2 blind technique, where you make an incision and 3 blindly place a port. You can also do something 4 called the open technique or Hasson technique, 5 H-a-s-s-o-n, I believe, and it's where you make a 6 larger incision through the umbilicus and visualize 7 going through the layers and placing the port under 8 direct visualization. 9 Q. When you say you blindly place a port, 10 what are you meaning by that? 11 A. You would just -- you're just not 12 looking through the layers as you place it. So some 13 people will do that. I don't do that. You can also 14 do the Optivue technique, where instead of blindly 15 placing the port, you are not visualizing going 16 through the layers of the abdominal wall, and you 17 can insert the 5-millimeter camera through a port. 18 That's never been shown to decrease complications, 19 but some feel more comfortable placing the device 20 that way. 21 Q. When you say some surgeons blindly place 22 the port, are you talking about a trocar? 23 A. Some will; correct. 24 Q. So when you said port, that's -- 25 A. Trocar.</p>

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<p>1 Q. That's the equivalent of a trocar?</p> <p>2 A. Yes. Yes.</p> <p>3 Q. Is the insertion of the varus needle</p> <p>4 into the abdomen a blind procedure as well?</p> <p>5 A. Yes.</p> <p>6 Q. Are there risks with that?</p> <p>7 A. Very few.</p> <p>8 Q. What are they?</p> <p>9 A. There are risks of damaging the bowel,</p> <p>10 large vessels in the abdomen, the bladder,</p> <p>11 potentially. But the patients that we use the varus</p> <p>12 needle on, you decrease their risk by not performing</p> <p>13 it in people who have had previous abdominal</p> <p>14 procedures. You can also place it in a left upper</p> <p>15 quadrant, if you are trying to avoid a prior midline</p> <p>16 incision. So there are various ways to use the</p> <p>17 varus needles, but the varus needle is a very safe</p> <p>18 device.</p> <p>19 Q. You've probably read the literature</p> <p>20 which reports various rates of injury to patients</p> <p>21 receiving blind varus needle entry during the time</p> <p>22 of laparoscopy?</p> <p>23 A. Am I familiar with it?</p> <p>24 Q. Um-hum.</p> <p>25 A. I am.</p>	<p>1 pain or chronic, post-surgical pain. I don't -- I</p> <p>2 mean, because everyone -- I mean, almost everyone</p> <p>3 that has surgery has some pain associated with it.</p> <p>4 Q. How do you define chronic pain?</p> <p>5 A. What kind of chronic pain?</p> <p>6 Q. I'm asking you.</p> <p>7 A. Like chronic pelvic pain would be --</p> <p>8 that would be the thing I'm most familiar with. So</p> <p>9 chronic pelvic pain would be continuous or</p> <p>10 intermittent time period the same pain for greater</p> <p>11 than six months.</p> <p>12 Q. Is that statement that the chronic</p> <p>13 pain -- strike that.</p> <p>14 Is the statement you just made that</p> <p>15 chronic pelvic pain is pain that persists for more</p> <p>16 than six months a statement that comes out of one of</p> <p>17 the professional organization guidelines, like the</p> <p>18 Ob/Gyn or urology?</p> <p>19 A. ACOG?</p> <p>20 Q. Yes.</p> <p>21 A. And most of them do say six months.</p> <p>22 Some organizations will say as little as three</p> <p>23 months, but most, to my knowledge, are six months.</p> <p>24 Q. Your standard for chronic pelvic pain,</p> <p>25 though, is six months for consistent pain?</p>
<p style="text-align: center;">Page 35</p> <p>1 Q. And you believe that the risks are, did</p> <p>2 you say, very few or low?</p> <p>3 A. Yes. They're significantly less than</p> <p>4 1 percent.</p> <p>5 Q. Okay. I take it, when you were doing</p> <p>6 the transvaginal slings during your residency, you</p> <p>7 were involved in counseling of those patients about</p> <p>8 the risks of the surgery?</p> <p>9 A. I was.</p> <p>10 Q. Were you involved in counseling patients</p> <p>11 about the risks of other incontinence surgeries like</p> <p>12 the Burch as well?</p> <p>13 A. I was.</p> <p>14 Q. Were you involved in counseling patients</p> <p>15 about the risks of prolapse repairs?</p> <p>16 A. Yes.</p> <p>17 Q. When did you first learn that pain was a</p> <p>18 potential complication with surgery?</p> <p>19 A. Whenever?</p> <p>20 Q. Yes.</p> <p>21 A. I mean, it's medical school.</p> <p>22 Q. When did you first learn that pain was a</p> <p>23 potential complication with a vaginal surgery?</p> <p>24 A. Can you clarify? Are you talking about</p> <p>25 acute pain immediately after surgery or subacute</p>	<p style="text-align: center;">Page 37</p> <p>1 A. Of the same pain; correct. And that's</p> <p>2 what I would use from a research standpoint as well.</p> <p>3 Q. So when did you first learn that chronic</p> <p>4 pain was a risk of surgery?</p> <p>5 A. I think you're introduced to some of</p> <p>6 that in medical school. It's not common after most</p> <p>7 surgeries. So I would probably say the -- my --</p> <p>8 most of my education was in -- began in residency.</p> <p>9 And then I learned a significantly larger amount in</p> <p>10 fellowship at my additional training.</p> <p>11 Q. When did you first learn that</p> <p>12 dyspareunia was a potential risk with the vaginal</p> <p>13 surgery?</p> <p>14 A. Which type of vaginal surgery?</p> <p>15 Q. Any type of vaginal surgery.</p> <p>16 A. I think you have to kind of specify</p> <p>17 because there are certain procedures that we avoid</p> <p>18 now due to the risk of dyspareunia. And it depends</p> <p>19 on what type of dyspareunia, insertional, deep</p> <p>20 dyspareunia. Is it painful at the beginning of</p> <p>21 intercourse, but then it dissipates once she's well</p> <p>22 lubricated. Is it -- you know, there's multiple</p> <p>23 different types. Is it provoked vestibulodynia. Is</p> <p>24 it scarring from a posterior repair. Is it pelvic</p> <p>25 floor tension. Is it structural, such as bladder,</p>

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<p>1 the bowel, the cervix, the uterus. I mean, I would 2 need you to specify.</p> <p>3 Q. How about this: Are there any vaginal 4 surgeries that you do that do not have the potential 5 risk of dyspareunia?</p> <p>6 A. Dyspareunia as in?</p> <p>7 Q. Pain with intercourse.</p> <p>8 A. At the opening of the vagina? At the --</p> <p>9 Q. Any time.</p> <p>10 A. In like how long -- I mean, immediately 11 after? 6 months? 12 months? I --</p> <p>12 Q. My question is broader. My question is 13 simply: Are there any vaginal surgeries you do that 14 do not have a potential risk of dyspareunia?</p> <p>15 A. I don't think I can answer that.</p> <p>16 MR. KUNTZ: Objection. Objection.</p> <p>17 Q. BY MR. SNELL: You can answer.</p> <p>18 A. I can't answer. I mean, I think it's 19 just too broad. I would really need you to specify 20 like a vestibulitis or provoked vestibulodynia. Is 21 it painful just -- I mean, I would need a more 22 specific question.</p> <p>23 Q. If you're doing a hysterectomy --</p> <p>24 A. Okay.</p> <p>25 Q. -- is there a potential risk of</p>	<p>1 women into physical therapy after surgery to improve 2 their outcomes.</p> <p>3 Q. What's the -- what's the physical 4 therapy regimen? Is it to break up the scar tissue?</p> <p>5 A. To mobilize the tissue, yes. And also a 6 huge part of physical therapy is the cognitive 7 behavior therapy component. So you have a woman who 8 has not been able to have pain-free intercourse for 9 either her entire life or a period of months to 10 years. And one of the most important parts of 11 physical therapy is having her more -- become more 12 comfortable with inserting things into the vagina, 13 feeling more comfortable with her own body. I think 14 that is another component of it as well. It also 15 treats any musculoskeletal pain that they may have 16 from either surgery or prior to surgery from the 17 pain process itself.</p> <p>18 MR. KUNTZ: Burt, whenever you get to a 19 stopping point, let me know.</p> <p>20 MR. SNELL: We can stop now.</p> <p>21 MR. KUNTZ: I just want to take a quick 22 break.</p> <p>23 (Recessed from 10:08 a.m. to 24 10:17 a.m.)</p> <p>25 Q. BY MR. SNELL: The web site identifies</p>
<p style="text-align: center;">Page 39</p> <p>1 dyspareunia after that?</p> <p>2 A. Insertional dyspareunia, probably 3 incredibly low.</p> <p>4 Mid or deep dyspareunia, there's a low 5 risk.</p> <p>6 Q. Do you counsel your patients on that?</p> <p>7 A. I do.</p> <p>8 Q. That's what I'm getting at, you know, 9 what type of vaginal surgeries do you do where 10 there's a risk of dyspareunia?</p> <p>11 A. I know I don't place mesh. I think that 12 risk is great.</p> <p>13 MR. SNELL: Move to strike as 14 nonresponsive.</p> <p>15 Q. BY MR. SNELL: What type of surgeries do 16 you do that have a risk of dyspareunia that you 17 counsel your patients on?</p> <p>18 A. For example, the vestibulectomy.</p> <p>19 Q. Okay.</p> <p>20 A. Which is a procedure we do to remove the 21 vestibule which is causing pain.</p> <p>22 Q. Um-hum.</p> <p>23 A. One of the potential risks would be 24 scarring of the posterior vagina.</p> <p>25 However, we probably would get these</p>	<p style="text-align: center;">Page 41</p> <p>1 you as treating chronic pain disorder and pelvic 2 pain; is that correct?</p> <p>3 A. Is that my web site?</p> <p>4 Q. I believe so. Clinical practice focused 5 on pain management, pelvic pain.</p> <p>6 A. That would be correct.</p> <p>7 Q. And some of the pain management and 8 pelvic pain that you deal with is chronic pelvic 9 pain or chronic pain?</p> <p>10 A. Almost all of my pain is chronic.</p> <p>11 Q. And what are the conditions that lead to 12 that chronic pain that you treat?</p> <p>13 A. Where would you like me to begin?</p> <p>14 Chronic pelvic pain?</p> <p>15 Q. Sure.</p> <p>16 A. It's a very broad topic. I probably 17 would just break it down by organ systems. I mean, 18 so it could be the reproductive system.</p> <p>19 Q. Okay.</p> <p>20 A. Well, if you look at -- so reproductive 21 system would include -- I mean, anything structural 22 with the reproductive organs themselves. So the 23 uterus: Necrotic fibroids, severe cramping with 24 menses called dysmenorrhea, distention of the 25 fallopian tubes, such as hydrosalpinges or</p>

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<p>1 pyosalpinges, from an inflammatory disease of the 2 pelvis, such as like pelvic inflammatory disease, a 3 chlamydia infection. You can have chronic pain from 4 those conditions. You can have chronic pain from 5 endometriosis.</p> <p>6 Q. Is that structural?</p> <p>7 A. It -- I mean, it has implants. So it is 8 a -- you would -- implants are large masses on the 9 ovaries or nodules of the uterosacral ligament. So 10 it is -- I mean, it's structural.</p> <p>11 Then you could have the GI tract. So 12 you could have inflammatory bowel disease, irritable 13 bowel syndrome can be associated with some pain. 14 Diverticulitis can be an ebb and flow of chronicity 15 and cause some pain.</p> <p>16 Chronic appendicitis. The GU syndrome 17 or -- so you have interstitial cystitis. Painful 18 bladder syndrome. Chronic ureteritis, chronic 19 urinary tract infections, a foreign body in the 20 bladder can cause chronic pain, like a stone -- 21 residual stone or -- like from a renal stone, a 22 suture. Like those can actually cause chronic 23 discomfort in contractability of the bladder.</p> <p>24 You can have the pelvic floor muscles. 25 Those are normally in response to something, but</p>	<p>1 University of Kansas or do you split time between 2 the University of Kansas And University of North 3 Carolina?</p> <p>4 A. Now all my practice is at the University 5 of Kansas.</p> <p>6 Q. Do you -- when you do your surgeries, do 7 you use -- I take it you use sutures during your 8 surgeries; correct?</p> <p>9 A. I do.</p> <p>10 Q. Do you use any polypropylene sutures?</p> <p>11 A. Not in the surgeries I perform now.</p> <p>12 Q. Did you ever use any polypropylene 13 sutures for any of your surgeries?</p> <p>14 A. I'm sure during residency I have.</p> <p>15 Q. Do you use any permanent sutures in your 16 surgeries?</p> <p>17 A. I currently don't. I will use some -- 18 I'll use some silk to oversew the bowel, if there's 19 a bowel injury. But actually -- yeah. I'm trying 20 to think. I don't think I do now. I'm just trying 21 to go through all my procedures. I use a -- no. 22 Never mind. No. I use -- I was just trying to 23 think of all my things.</p> <p>24 I occasionally will use a Hem-o-Lok clip 25 on an appendix -- of appendix, but that's the only</p>
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<p>1 they can definitely contribute to chronic pain of 2 the pelvis. So that would be the levator ani 3 complex and the obturator muscle, the piriformis 4 muscles. You can have a neuropathic condition of 5 the lower abdominal wall or the pelvis. So that 6 would be -- you could have an ilioinguinal or 7 iliohypogastric neuropathy, genitofemoral 8 neuropathy, obturator neuropathy, pudendal 9 neuropathy. All of those can cause chronic pelvic 10 pain.</p> <p>11 You can have something like -- the 12 musculoskeletal system, like the hip, is in close 13 proximity to the pelvis.</p> <p>14 Q. The hip?</p> <p>15 A. The hip. So I've had patients who have 16 had a labrale tear, but they describe it as groin 17 and pelvic pain and end up in my clinic, but it's 18 usually orthopedic in nature. I would say those are 19 the most common that I see, just off the top of my 20 head.</p> <p>21 Q. Okay.</p> <p>22 A. And then you have, you know, vulvar pain 23 syndrome. So generalized vulvodynia, provoked 24 vestibulodynia.</p> <p>25 Q. Is all of your current practice at the</p>	<p>1 thing that is non-absorbable.</p> <p>2 Q. So a little while ago we discussed the 3 different conditions that could lead to chronic 4 pelvic pain.</p> <p>5 Can you tell me the different conditions 6 that can lead to -- strike that.</p> <p>7 Do you consider chronic dyspareunia to 8 be within the realm of chronic pelvic pain?</p> <p>9 A. I do. Yeah.</p> <p>10 Q. The conditions that can lead to chronic 11 dyspareunia, are those the same as those you 12 enumerated with respect to chronic pelvic pain? The 13 structural endometriosis, GI tract, GU, pelvic floor 14 muscles, neuropathic, musculoskeletal and vulvar 15 pain syndromes?</p> <p>16 A. I think the one thing I also excluded, 17 and it's blatantly obvious, is the mesh conditions 18 as well. So foreign body in the vagina. And I 19 would say that some of those could contribute to 20 dyspareunia, but it depends on the type of 21 dyspareunia. And that's really important in my 22 clinical practice, because it allows me to have a 23 true diagnosis and then actually treat my patients.</p> <p>24 Q. When a patient comes in and she's 25 complaining of pain, walk me through the process of</p>

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<p>1 how you would assess her? Starting with, you know, 2 she's a new patient of yours.</p> <p>3 A. Sure.</p> <p>4 Q. Let me just clean the question up.</p> <p>5 A. Okay.</p> <p>6 Q. So walk me through the process by which 7 you evaluate a new patient.</p> <p>8 A. Okay. A new any patient?</p> <p>9 Q. A new patient with pain.</p> <p>10 A. Patient with pain.</p> <p>11 So my practice is a -- is a pelvic pain 12 and sexual health practice. The majority of my 13 patients who have been referred are referred from 14 either clinicians within my department to my 15 division or within the University of Kansas or 16 outside. So it's a referral-based practice.</p> <p>17 Q. Okay.</p> <p>18 A. With a large catchment area.</p> <p>19 Most patients who have presented to me 20 have a diagnosis of chronic pain, and have tried 21 multiple treatments and therapies prior to a 22 referral to myself. So that just is a normal 23 patient I see.</p> <p>24 So the -- when the patient arrives, she 25 may or may not have outside medical records. If she</p>	<p>1 traditionally I would -- detailed examination of the 2 vulva, including the labia majora, labia minora, the 3 clitoris, the clitoral hood, the urethra, the vulvar 4 vestibule, the hymenal ring, the anus. This is all 5 an inspection.</p> <p>6 I want to make sure that the tissue 7 appears normal. I want to identify if there's any 8 tenderness or erythema of the tissue. I'll use a 9 Q-Tip -- I'll perform a Q-Tip exam, where I'll 10 evaluate the vulvar vestibule. If she has no other 11 complaints of the vulva, I don't perform a 12 neurosensory exam of the vulva. That's more 13 detailed.</p> <p>14 I'll then lightly lubricate the Q-Tip, 15 and I'll insert it into the vagina and assess her 16 response. Is that neutral or unpleasant. I will 17 then use a single digit. I'll have her perform a 18 contraction of her pelvic floor muscles to assess 19 her Kegel strength.</p> <p>20 I then will perform the pelvic floor 21 muscle exam, applying approximately 2 kilograms of 22 pressures to the levator ani muscles, the obturator 23 internus, and the piriformis muscles bilaterally. 24 When I evaluate the obturator internus muscle, I 25 will have her abduct her thigh in order to fully</p>
<p style="text-align: center;">Page 47</p> <p>1 does not, I would send a request for those. I think 2 an important part of what I do is to make sure we 3 don't duplicate treatments that have been performed 4 and not worked, as well as medications.</p> <p>5 And then I have approximately 60 minutes 6 with the patient, for my new patients. We do a 7 detailed history, which I think is incredibly 8 important in deciphering the etiology of her pain, 9 aggravating and alleviating factors, but potential 10 trigger for her initial pain process, and then 11 subsequent responses from the remainder of her 12 symptoms.</p> <p>13 I then -- after a detailed history -- 14 I'm not going to go into that with you, but it's 15 very similar to what I have given you for 16 Ms. Huskey -- perform a thorough physical 17 examination. And that includes an examination of 18 the patient's back. So musculoskeletal system, her 19 abdomen, and the pelvic exam. You have a visual 20 inspection of the external genitalia.</p> <p>21 Do you want me to go into the pelvic 22 exam?</p> <p>23 Q. Yes.</p> <p>24 A. So -- I mean, you would definitively be 25 led by what some of her complaints are, but</p>	<p style="text-align: center;">Page 49</p> <p>1 palpate the muscle.</p> <p>2 And then I will ask her, as I evaluate 3 each of these muscles, if she has a pain or pressure 4 response. I'm also able to assess tonicity of the 5 muscles. So if they're -- if they're normal or if 6 they are hypertonic or contracting.</p> <p>7 And then I will evaluate the urethra, to 8 see if she has any tenderness in the urethra itself, 9 the bladder neck and the base of the bladder. I'll 10 use a single digit to see if she has any discomfort 11 behind the pubic arch.</p> <p>12 And then we'll perform a two-digit exam 13 to manipulate the cervix, to see if she has cervical 14 tenderness. I will then evaluate the mobility and 15 size of the uterus, see if she has any tenderness of 16 the uterus. I will then apply my abdominal hand to 17 evaluate the size of the uterus, evaluate the 18 adnexa, see if there's any tenderness or fullness in 19 the adnexa.</p> <p>20 I'll perform a rectovaginal exam. The 21 patients that have complaints of -- defecatory 22 complaints, evaluate the rectovaginal septum, and 23 then change gloves and perform a speculum exam.</p> <p>24 So we'll look at the vagina, looking 25 for -- I already would do an initial assessment of</p>

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<p>1 the introitus at the beginning looking for genital 2 atrophy. I insert the speculum. I'm looking for 3 any lesions, abnormal discharge, erythema of the 4 cervix, any structural changes of the vagina itself. 5 I also assess the vaginal walls with a Q-Tip to see 6 if she has any tenderness elucidated along the 7 vaginal sidewalls and the vaginal apex.</p> <p>8 If she's had a hysterectomy, I'll also 9 palpate the vaginal cuff to see if she has any 10 tenderness of the cuff itself during the speculum 11 exam.</p> <p>12 One thing that's very important is that 13 during the exam, if the woman has reported pain with 14 intercourse, I use the examination and her history 15 to provide a more thorough picture of where her 16 dyspareunia would be. So if she says she has 17 insertional pain, I take time to really focus on the 18 opening of the vagina, the levators, the structure 19 of the vagina, the urethra. And then I ask her, is 20 this the pain that you feel with intercourse. So I 21 try to reproduce the pain. It helps me create my 22 plan and decide what our next steps are.</p> <p>23 And in my patients who have had a mesh 24 procedure before, I look for any erosive disease, 25 general atrophy, scarring around the mesh,</p>	<p>1 Q. Okay. Do you do pain mapping on your 2 patients?</p> <p>3 A. Could you clarify that term?</p> <p>4 Q. You don't know what pain mapping is?</p> <p>5 A. I mean, do I do an evaluation to 6 identify pain? The way I know pain mapping is a 7 technique that is rarely performed. It is a 8 laparoscopic technique. I do a thorough examination 9 in some patients who have specific vulvar complaints 10 in neurosensory exam.</p> <p>11 Q. Have you written on pain mapping, 12 published about it?</p> <p>13 A. It's been described by John Steege 14 before. But it's not something we use regularly in 15 our practice.</p> <p>16 Q. Why don't you regularly use pain mapping 17 in your practice?</p> <p>18 A. It's invasive, and, from my 19 understanding, has not produced the results that 20 they had expected. So there's -- it's patient 21 selection.</p> <p>22 And are you -- are you -- are you 23 talking about the laparoscopic pain mapping? I just 24 want to make sure I understand what you're saying, 25 or just pain mapping as doing a thorough physical</p>
<p>1 displacement of the urethra from scarring or any 2 folding or changes in the anatomy of the mesh 3 through the vaginal epithelium.</p> <p>4 Q. Do you use questionnaires for your 5 patients?</p> <p>6 A. We have a review of symptoms sheet that 7 is mandated by the university that we use. In my 8 new patients, there is a sheet on -- provided for 9 medications and allergies, but I do not use any 10 validated questionnaires at this time.</p> <p>11 One of my problems with the 12 questionnaires we do have for sexual function in 13 assessing any type of pain is it's not specific 14 enough. So even if -- first of all, the women are 15 coming to me because they have a pain complaint or 16 sexual dysfunction complaint. And secondly, it's 17 not specific enough to really provide any useful 18 information for me during my clinical visit. Where 19 I think it may be helpful is as my practice 20 continues to expand, it would be looking at -- from 21 a research standpoint at maybe a way to evaluate 22 improvement.</p> <p>23 However, these -- the questionnaires we 24 have currently for sexual health and pelvic pain are 25 not specific enough, in my opinion.</p>	<p>1 exam and neurosensory exam? I guess I don't know 2 which one you're asking.</p> <p>3 Q. You were testifying about laparoscopic 4 pain mapping; correct?</p> <p>5 A. Yes. But is that what you were asking?</p> <p>6 Q. Yeah. I was asking about the pain 7 mapping that Dr. Steege has written about and that 8 you would have been trained on, I assume.</p> <p>9 A. We have done it before. It is designed 10 for an attempt to evaluate visceral pain. So just 11 to kind of clarify, visceral pain is going to be 12 defuse nonspecific pain.</p> <p>13 And the idea behind pain mapping is, 14 well, if we put our patients to sleep and we go in 15 and we touch their visceral structures, like the 16 bladder, the bowel, the uterus, the ovary, maybe 17 they can tell us if that's where they feel their 18 pain.</p> <p>19 The problem is that's not how visceral 20 innervation works. It works when I -- visceral 21 innervation is very different than somatic 22 innervation. Somatic is if you close your eyes and 23 I touch you on your right index finger, you know 24 exactly where I'm touching you. The idea is trying 25 to apply that to the pelvic viscera, and that's why</p>

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<p>1 it's really clinically inconclusive. And we don't 2 use it regularly in practice because you can't just 3 close someone's eyes and go in and say, is this your 4 pain, because it's really difficult to do.</p> <p>5 Q. Are you board certified in female pelvic 6 medicine and reconstructive surgery?</p> <p>7 A. I'm a board certified obstetrician and 8 gynecologist. Not a urogynecologist. That was not 9 my training.</p> <p>10 Q. You have not sat for the female pelvic 11 medicine and reconstructive subspecialty boards?</p> <p>12 A. That was not my fellowship training, so, 13 no.</p> <p>14 Q. Do you have any intention of taking 15 those subspecialty boards, female pelvic medicine 16 and reconstructive surgery?</p> <p>17 A. I have no intention of doing a 18 fellowship in urogynecology. I've done enough 19 fellowships.</p> <p>20 Q. Your CV lists the professional 21 organizations you are a member of; correct?</p> <p>22 A. Correct.</p> <p>23 Q. What's the value of being associated 24 with those organizations?</p> <p>25 A. As far as the -- I'm an active member in</p>	<p>1 A. Sure. 2 Q. -- with pain. 3 A. Sure. 4 Q. Do you usually have a second doctor 5 there in the room with you?</p> <p>6 A. I usually have a medical student or 7 resident in the room with me, which is a great 8 platform for teaching. Because my specialty is 9 unique, I have a lot of learners, which is really 10 fun for me to teach on a clinical level. So I often 11 do have someone with me.</p> <p>12 Q. Am I correct, though, that when you see 13 your patients for pain, you do not normally see them 14 with another doctor who also is experienced in pain 15 management at the same time?</p> <p>16 A. Not normally. However, within my 17 center, we have a total of four providers, and we do 18 patient share quite a bit. So especially with our 19 very difficult, complex patients, where there's not 20 a lot of treatment options, we will patient share. 21 So I will see someone and then refer them within a 22 very short time period -- not within the same visit, 23 but in a very short time period to maybe one of my 24 other colleagues who has maybe a different view on a 25 patient or a different clinical interest.</p>
<p style="text-align: center;">Page 55</p> <p>1 all of the organizations I have listed. I believe 2 most -- American College of Obstetricians and 3 Gynecologists actually has one of the highest 4 membership rates of any specialty, which is -- is 5 wonderful to be a part of. They provide a -- I 6 mean, a collegiality. I mean, you go to meetings 7 with these groups. They provide some structure. 8 They don't always represent the ideas of the -- all 9 of the members. So that's something to keep in 10 mind. But they, in general, will provide some 11 recommendations based on opinion that can help guide 12 practitioners. It allows for a forum for debate, 13 intellectual community.</p> <p>14 I mean, I think that all of the 15 organizations I'm involved in, at least, provide 16 that for me. I'm also involved in -- heavily 17 involved in the International Pelvic Pain Society, 18 including development of their basics pain course. 19 And I'm looking forward to future leadership 20 positions in both that community as well as 21 Association of American Gynecological 22 Laparoscopists, AAGL.</p> <p>23 Q. I forgot to ask you: Earlier you were 24 testifying about your procedure for evaluating a new 25 patient who comes in --</p>	<p style="text-align: center;">Page 57</p> <p>1 We also will have a pain board meeting 2 once a month, where we work with not only all of the 3 providers in my practice for the Center for Pelvic 4 Pain and Sexual Health, we work with a sexual 5 therapist, who sees a majority of our patients who 6 have sexual dysfunction that may have resulted from 7 one of their pain conditions. And we also work with 8 two physical therapists who do nothing but pelvic 9 floor health. And so we meet on a regular basis to 10 discuss those difficult patients.</p> <p>11 Q. When you evaluated Mrs. Huskey, 12 Dr. Steege was present; correct?</p> <p>13 A. We did the exam together. We did the 14 interview separately.</p> <p>15 Q. In your normal practice, you do not 16 normally do the exam of a patient with another 17 doctor like Dr. Steege; correct?</p> <p>18 A. I wish I could.</p> <p>19 Q. Is the answer to my question that's 20 correct?</p> <p>21 A. Not in a normal practice, but I would 22 like to clarify that in our mesh pain clinic in 23 fellowship that was run by both a pain doctor like 24 myself and a urogynecologist. So in those mesh pain 25 patients, we had two sets of consultant level eyes</p>

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<p style="text-align: center;">Page 58</p> <p>1 on those women because they're complicated. 2 And really what we were trying to decide 3 there is, is it beneficial to remove this mesh. 4 Will the person get better? Should we do something 5 that is less invasive. So in that setting, that 6 was -- that was different, and I wish we had that 7 for all of our patients.</p> <p>8 Q. Well, when you say there was two sets of 9 consultant level eyes, you're not saying that the 10 pain doctor and the urogynecologist would both be 11 present at the same time?</p> <p>12 A. Correct. They would be.</p> <p>13 Q. And that was at UNC?</p> <p>14 A. Yes.</p> <p>15 Q. Am I correct that in your normal clinic 16 it would not be the case that you and a doctor like 17 Dr. Steege, who is a pain doctor, would both 18 evaluate the patient at the same time?</p> <p>19 A. In normal GYN clinic, no.</p> <p>20 Q. I'm not correct?</p> <p>21 A. I mean, that is correct. But in most of 22 those cases, there's not complex pain syndromes that 23 you're evaluating as well.</p> <p>24 Q. Is it correct then that most of your 25 patients do not have complex pain syndromes?</p>	<p style="text-align: center;">Page 60</p> <p>1 provide John Steege, our combined physical 2 examination, and try to factor out the etiology of 3 their chronic pain.</p> <p>4 In the patients that we've seen, not all 5 of them we -- our conclusions were not that mesh 6 caused their pain in all of them.</p> <p>7 Q. You're aware I took Dr. Steege's 8 deposition?</p> <p>9 A. Yes.</p> <p>10 Q. You read his transcript?</p> <p>11 A. I did.</p> <p>12 Q. Okay.</p> <p>13 A. I don't know if I read it all word for 14 word, but I glanced over it.</p> <p>15 Q. You're being paid by the plaintiffs in 16 this case?</p> <p>17 A. Most medical experts are paid, yes. I 18 am being paid.</p> <p>19 MR. SNELL: Move to strike. Move to 20 strike.</p> <p>21 Q. BY MR. SNELL: It's a simple yes or no.</p> <p>22 A. Yes.</p> <p>23 Q. Let me just ask it plainly. What I want 24 here is to have a record. Simple questions, I would 25 appreciate it if you would say yes or no.</p>
<p style="text-align: center;">Page 59</p> <p>1 A. Most of my patients have a chronic pain 2 syndrome. If I had the ability to have someone 3 assist me with my mesh pain patients, I absolutely 4 would. I mean, I'm kind of the end of the road with 5 these patients, and there's not a lot of guidance in 6 the management of their care. So I'm constantly 7 asking questions and querying my urogynecologists, 8 not in the same clinic, but regarding the same 9 patients, absolutely. Asking them, you know, do you 10 think mesh removal in this person would be helpful. 11 Do you think this person might benefit from 12 neuromodulation. Do you think this person might, 13 even though she failed the trial one medication, do 14 well with another. I mean, that's my clinical 15 practice.</p> <p>16 Q. At the time you evaluated Mrs. Huskey, 17 you knew she was involved in litigation; correct?</p> <p>18 A. I did.</p> <p>19 Q. How many times previous to this case 20 have you been an expert in a litigation matter?</p> <p>21 A. I've been acting as an independent 22 medical examiner for about 15 to 20 patients. My 23 role is to, as independently as possible, evaluate 24 the patient's medical record, the history they 25 provide me at the visit I see them, the history they</p>	<p style="text-align: center;">Page 61</p> <p>1 You're here paid by the plaintiffs 2 today; correct?</p> <p>3 A. I am.</p> <p>4 Q. And you're an expert for the plaintiff; 5 correct?</p> <p>6 A. I'm a medical expert, yes.</p> <p>7 Q. And what is -- when do -- strike that.</p> <p>8 When were you first retained for this 9 Huskey case?</p> <p>10 A. I believe I saw her in January. I don't 11 know the exact date of the exam. She was 12 examined -- we saw her January 11, 2014.</p> <p>13 Q. When were you first retained by the 14 plaintiffs to be an expert in the mesh litigation?</p> <p>15 A. The first patient I saw was in the 16 spring, I believe, April of 2013.</p> <p>17 Q. Which attorney or law firm retained you?</p> <p>18 A. Mueller law.</p> <p>19 Q. Mark Mueller's law firm?</p> <p>20 A. Margaret Thompson. I was approached by 21 Margaret Thompson and John Steege to evaluate these 22 patients because of my additional training with pain 23 anesthesia. But I think that is the law firm.</p> <p>24 Q. Okay. So you were initially approached 25 by Margaret Thompson and Dr. Steege to participate</p>

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<p>1 as an expert in this litigation?</p> <p>2 A. Yes.</p> <p>3 Q. And were you told what your role would</p> <p>4 be?</p> <p>5 A. As an independent medical examiner.</p> <p>6 Q. Was it your understanding that you would</p> <p>7 be evaluating patients at the same time as</p> <p>8 Dr. Steege?</p> <p>9 A. Yes. And part of that was logistics. I</p> <p>10 had moved to Kansas City. So they ended up trying</p> <p>11 to make it in one -- a one-day visit so I could fly</p> <p>12 into North Carolina and we could evaluate -- have</p> <p>13 the patient fly only one time and see both of us.</p> <p>14 So all of our interviews were</p> <p>15 independent and the medical exam was performed</p> <p>16 together.</p> <p>17 Q. Did you bring your invoices or billing</p> <p>18 to the deposition?</p> <p>19 A. I have not billed for Ms. Huskey's case.</p> <p>20 Q. How much have you billed in the mesh</p> <p>21 litigation while serving as a plaintiff's expert?</p> <p>22 A. I have billed approximately -- I think</p> <p>23 80 hours is what I've billed so far.</p> <p>24 Q. And who do you usually send those</p> <p>25 invoices to?</p>	<p>1 the Huskey case?</p> <p>2 A. The -- are you talking about a financial</p> <p>3 retainer?</p> <p>4 Q. No. I mean --</p> <p>5 A. The ones where I was asked to do it?</p> <p>6 Q. Yeah. Let me just make it simple.</p> <p>7 A. Okay.</p> <p>8 Q. When were you first asked to serve as an</p> <p>9 expert in the Huskey case?</p> <p>10 A. To serve as an expert. I was asked to</p> <p>11 write a rebuttal to Dr. Pradmudji's opinions, and</p> <p>12 that was in April of 2014. So up until that point,</p> <p>13 I had not planned on testifying as a medical expert,</p> <p>14 but I was asked to write the rebuttal.</p> <p>15 Q. When were you first requested to be</p> <p>16 involved in Mrs. Huskey's -- maybe we're not</p> <p>17 communicating. Maybe my question is incorrect.</p> <p>18 A. I'm sorry.</p> <p>19 Q. That's okay.</p> <p>20 So you evaluated Mrs. Huskey back in</p> <p>21 January of 2014; correct?</p> <p>22 A. As I had been doing -- correct, with</p> <p>23 other cases.</p> <p>24 Q. And you don't do those for free;</p> <p>25 correct?</p>
<p style="text-align: center;">Page 63</p> <p>1 A. To Mueller law.</p> <p>2 MR. KUNTZ: Just note our objection to</p> <p>3 that request, but you can ask her about it.</p> <p>4 MR. SNELL: Well, I'm going to demand --</p> <p>5 ask production.</p> <p>6 Q. BY MR. SNELL: You didn't bring those</p> <p>7 invoices with you here today; did you?</p> <p>8 MR. KUNTZ: We'll object. We're not</p> <p>9 producing invoices aside from the Huskey case, and</p> <p>10 one doesn't exist.</p> <p>11 MR. SNELL: Well, I'll ask for it, but I</p> <p>12 understand your objection.</p> <p>13 Q. BY MR. SNELL: You have not billed for</p> <p>14 the Huskey case?</p> <p>15 A. No.</p> <p>16 Q. How many hours have you spent on the</p> <p>17 Huskey case?</p> <p>18 A. Including my deposition prep,</p> <p>19 approximately 50 hours.</p> <p>20 Q. So you have spent approximately 50 hours</p> <p>21 on the Huskey case?</p> <p>22 A. Reviewing the literature -- or reviewing</p> <p>23 the medical records; that's correct.</p> <p>24 Q. How were you -- strike that.</p> <p>25 When were you first retained to work on</p>	<p style="text-align: center;">Page 65</p> <p>1 A. Correct.</p> <p>2 Q. You expect to be paid?</p> <p>3 A. Correct.</p> <p>4 Q. When you evaluated Mrs. Huskey, you</p> <p>5 expected to be paid?</p> <p>6 A. As a medical examiner, yes.</p> <p>7 Q. By the plaintiff's law firm; correct?</p> <p>8 A. Correct.</p> <p>9 Q. So how did you first come to learn about</p> <p>10 the Huskey case?</p> <p>11 A. I guess I -- I mean, I saw her January</p> <p>12 of 2011 -- or of 2014. January 11, 2014, was when I</p> <p>13 did perform her medical exam.</p> <p>14 I was asked to address Dr. Pradmudji's</p> <p>15 opinions and write a rebuttal in April of 2014.</p> <p>16 Q. How did you know that you were supposed</p> <p>17 to go and evaluate Mrs. Huskey on January 11th,</p> <p>18 2014?</p> <p>19 A. Because I had been asked to be a medical</p> <p>20 examiner.</p> <p>21 Q. Okay. When were you asked to be a</p> <p>22 medical examiner to see Mrs. Huskey?</p> <p>23 A. The date?</p> <p>24 Q. Yes.</p> <p>25 A. Oh. It was pretty last minute. So I</p>

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<p>1 don't -- I mean, it was -- my travel plans were not 2 finalized for that trip until, I think, January -- 3 early January. I can't remember the exact date. 4 But --</p> <p>5 Q. You didn't know Mrs. Huskey before you 6 saw her; correct?</p> <p>7 A. No.</p> <p>8 Q. No, I'm not correct?</p> <p>9 A. No. I mean correct. You're correct. I 10 did not know her.</p> <p>11 Q. Who makes the travel plans when you 12 would do the independent medical examination of -- 13 strike that.</p> <p>14 Who makes these travel plans when you go 15 to evaluate Mrs. Huskey?</p> <p>16 A. The law firm.</p> <p>17 Q. And when did you get to North Carolina 18 for your examination of Mrs. Huskey?</p> <p>19 A. January 10th.</p> <p>20 Q. So you would come in the day before and 21 the next day do the evaluation?</p> <p>22 A. Correct.</p> <p>23 Q. What form of communication was used to 24 tell you to evaluate Mrs. Huskey?</p> <p>25 A. I think I was invited by email, but I</p>	<p>1 Q. Take a look at your deposition notice. 2 It's been marked as Exhibit 1. And I want to direct 3 you to Schedule A, which are documents relating to 4 the fees, billing, and time spent --</p> <p>5 A. Um-hum.</p> <p>6 Q. -- in connection with your opinions in 7 any pelvic mesh litigation.</p> <p>8 Did you bring any of these documents 9 here today?</p> <p>10 A. No, I have not completed my billing.</p> <p>11 Q. Okay. And for your billing on other 12 pelvic mesh cases, you have billed, but you have not 13 brought those here today; correct?</p> <p>14 A. I have not completed my billing on all 15 of them.</p> <p>16 MR. KUNTZ: I'll note our objection to 17 that request as well.</p> <p>18 Q. BY MR. SNELL: What is your hourly rate?</p> <p>19 A. \$500 an hour.</p> <p>20 Q. Is that for reviews, examinations, 21 testimony?</p> <p>22 A. Correct.</p> <p>23 Q. You don't have a flat fee for medical 24 examination?</p> <p>25 A. I didn't, no.</p>
<p style="text-align: center;">Page 67</p> <p>1 didn't receive -- I don't believe I received her 2 medical records until the day before.</p> <p>3 Q. When did you receive Mrs. Huskey's 4 medical records?</p> <p>5 A. We received them late. We received them 6 on the 10th, I believe.</p> <p>7 Q. And what medical records did you receive 8 from Mrs. Huskey on January 10th?</p> <p>9 A. I mean, I'm guessing. I did not look at 10 her medical records until after we saw her. So they 11 may have been available to me on the 10th, but I did 12 not look at them until later that week.</p> <p>13 Q. Okay.</p> <p>14 A. It's not uncommon for evaluating a 15 patient that's been referred that does not come 16 without medical records.</p> <p>17 Q. So you did not look at Mrs. Huskey's 18 medical records until after you had evaluated her?</p> <p>19 A. Yes.</p> <p>20 Q. And after your evaluation of 21 Mrs. Huskey, did you return back to Kansas City on 22 January 11th?</p> <p>23 A. I believe I returned on the -- I stayed 24 an additional day. So I returned on the 14th, I 25 believe. I stayed through the weekend.</p>	<p style="text-align: center;">Page 69</p> <p>1 Q. I'm sorry?</p> <p>2 A. I'm sorry. So when I was in North 3 Carolina, I would just bill the workday.</p> <p>4 Q. Okay.</p> <p>5 A. For the hourly fee.</p> <p>6 Q. You brought your CV.</p> <p>7 Have you ever given testimony before?</p> <p>8 A. No.</p> <p>9 Q. Okay. And your updated CV, now with the 10 addition of the one article we discussed, the 11 post-hysterectomy dyspareunia, that's up to date 12 with regard to your publications; correct?</p> <p>13 A. That should be, in addition to whatever 14 else is listed in my CV.</p> <p>15 Q. When you evaluated Mrs. Huskey, did you 16 make any notes?</p> <p>17 A. I did. On my computer.</p> <p>18 Q. Where are those notes?</p> <p>19 A. They ended up being a compilation of the 20 draft.</p> <p>21 Q. You still have those notes?</p> <p>22 A. I have drafts of those on my computer, 23 yes.</p> <p>24 Q. Okay.</p> <p>25 A. Though I may not have all of them. My</p>

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<p>1 hard drive on my computer, I don't know, April, 2 broke. But I have some copies, yes.</p> <p>3 Q. Did you send any of your notes from your 4 medical examination to Dr. Steege?</p> <p>5 A. He documented the medical exam, and then 6 we shared that documentation immediately after each 7 patient.</p> <p>8 Q. You say they would share -- strike that. 9 When you shared the documentation of the 10 medical examination with Dr. Steege, what do you 11 mean by that?</p> <p>12 A. We -- immediately after evaluating the 13 patient, we'd complete the physical exam component 14 to make sure we agreed on all areas of the exam.</p> <p>15 Q. And you completed this physical 16 examination component where you wanted to make sure 17 that you agreed on all elements of the exam.</p> <p>18 A. Yes.</p> <p>19 Q. What type of document was that?</p> <p>20 A. It was a Word document. That ended up 21 being the basis of this CV report.</p> <p>22 Q. And that Word document, do you have a 23 copy of it?</p> <p>24 A. I don't. I'm sure he does. It was on 25 his computer.</p>	<p>1 two separate providers take a history. It made the 2 reports more thorough.</p> <p>3 MR. SNELL: Move to strike. I don't 4 believe that was responsive to my question.</p> <p>5 Q. BY MR. SNELL: Explain to me how the 6 examination of Mrs. Huskey occurred from the time 7 you arrived in North Carolina on the 10th.</p> <p>8 A. So I arrived on the 10th. I went to the 9 hotel. I went to sleep. I arrived very late. And 10 then in the morning we started approximately 11 8:00 a.m.</p> <p>12 We -- I mean, these are my colleagues 13 and mentors. I saw them at 8:00 a.m. And I don't 14 know what order she was, but we began seeing our 15 patients. And so we would each interview a patient 16 and then switch the patients. So I would have an 17 hour, and he would have approximately an hour to 18 interview the patient.</p> <p>19 We would then go into the exam room of 20 one patient together. I would perform the 21 musculoskeletal examination of the back, the lower 22 extremities, and then the neurosensory exam of the 23 vulva and vagina, and we both performed the 24 genitourinary exam.</p> <p>25 Q. And then after that?</p>
<p style="text-align: center;">Page 71</p> <p>1 Q. The Word document was never shared with 2 you?</p> <p>3 A. It was -- might have been emailed to me.</p> <p>4 Q. Did you bring that document here today?</p> <p>5 A. It ended up being a part of my -- or our 6 initial expert report. So I don't have that with 7 me.</p> <p>8 Q. Did you take any notes at the time of 9 your examination of Mrs. Huskey?</p> <p>10 A. Just a shared Word document.</p> <p>11 Q. But --</p> <p>12 A. No handwritten notes.</p> <p>13 Q. Okay. The shared Word document is the 14 document that was created in connection with the 15 evaluation of Mrs. Huskey?</p> <p>16 A. And it ended up being the basis of the 17 draft for the report. So we didn't have multiple 18 different documents flying around. Mostly for our 19 own organizational purposes, we'd have one chart for 20 Ms. Huskey, one chart for the next patient. It 21 makes it -- especially when you're taking the 22 history of multiple patients with very similar 23 complaints, it makes it very important that you have 24 it well documented, and that we agreed on the exam 25 and made sure the history was complete, hence having</p>	<p style="text-align: center;">Page 73</p> <p>1 A. And then we would have the patient 2 dress. We would discuss both the patient's history 3 and physical exam. And then we spoke with the 4 patient about our recommendations, because just as 5 much as they were there to be part of the 6 independent medical exam, we were some of the first 7 pelvic pain experts that several of them had seen. 8 And so we discussed what we believed would be the 9 most efficacious treatment options and interventions 10 for these patients. We talked to them about their 11 relationships with their partners, about the use of 12 physical therapy, sexual therapy. It was -- it 13 was -- and the women were incredibly grateful. So 14 it was, all in all, a wonderful experience.</p> <p>15 And then we would complete that single 16 patient and we'd go and examine the next patient. 17 It was a long day.</p> <p>18 Q. How many patients did you examine that 19 day?</p> <p>20 A. I don't know how many patients that day, 21 but normally between four and seven.</p> <p>22 Q. And were all of these patients patients 23 who are involved in litigation?</p> <p>24 A. All of them were.</p> <p>25 Q. When you saw Mrs. Huskey, am I correct</p>

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<p>1 that you took a history of her that lasted about an 2 hour?</p> <p>3 A. Correct.</p> <p>4 Q. Did you take any notes during that 5 history, or did you all just remember this in your 6 head?</p> <p>7 A. I took notes.</p> <p>8 Q. Did you bring those notes here today?</p> <p>9 A. Those were part of the combined draft.</p> <p>10 So I don't have them with me. I was --</p> <p>11 Q. The combined draft of what?</p> <p>12 A. Of the Steege expert report. So we both 13 took individual notes. They're basically a ghost of 14 that draft and then he combined them.</p> <p>15 Q. So Dr. Steege took your notes and put 16 them into your expert report?</p> <p>17 A. They were a compilation of both of our 18 histories; correct.</p> <p>19 Q. Do you still have your notes that you 20 took during your hour-long history of Mrs. Huskey?</p> <p>21 A. Ones that were not on the hard drive of 22 my computer that was destroyed, I can look for 23 those.</p> <p>24 Q. Did you ever email the lawyers or 25 Dr. Steege or anybody else your notes from your</p>	<p>1 Mrs. Huskey's doctors?</p> <p>2 A. No.</p> <p>3 Q. Okay. Have you ever spoken to any of 4 Mrs. Huskey's family members other than her husband?</p> <p>5 A. No.</p> <p>6 Q. Have you ever spoken to any of 7 Mrs. Huskey's therapists or other medical 8 professionals?</p> <p>9 A. No.</p> <p>10 Q. When you spoke with Mrs. Huskey 11 yesterday, how long did that conversation take 12 place?</p> <p>13 A. Approximately 30 minutes. And mostly it 14 was about her --</p> <p>15 Q. Well, let me -- that was responsive, the 16 30 minutes.</p> <p>17 Why'd you speak to Mrs. Huskey 18 yesterday?</p> <p>19 A. I wanted to clarify a couple of her 20 discrepancies in the Pradmudji report and the 21 history that she provided to us. I also wanted to 22 make sure I understood why she had a hysterectomy 23 and that she had never had a diagnosis of 24 endometriosis.</p> <p>25 Q. And these were all things that you did</p>
<p style="text-align: center;">Page 75</p> <p>1 history?</p> <p>2 A. I'm assuming that's how they got to 3 Dr. Steege.</p> <p>4 MR. SNELL: I'm going to ask for those 5 notes from the IME that she performed, particularly 6 the history she took from Mrs. Huskey.</p> <p>7 THE WITNESS: Sure. That's one of the 8 great things about it is, when we would meet 9 afterwards, we both elicited different bits of 10 information from the patient. And I think with his 11 expertise with sexual therapy, we were really 12 focusing on the relationship components of the 13 patients and their partners and lack of intimacy. 14 And then mine from more of a structural anesthesia 15 component. It made it a very thorough history.</p> <p>16 Q. BY MR. SNELL: Did you see Mrs. Huskey 17 after January 11th, 2014?</p> <p>18 A. I did not see her. I spoke with her 19 yesterday.</p> <p>20 Q. What was your understanding as to your 21 role in the Huskey case before you looked at 22 Dr. Pradmudji's report?</p> <p>23 A. That I was an independent medical 24 examiner.</p> <p>25 Q. Okay. Have you ever spoken to any of</p>	<p style="text-align: center;">Page 77</p> <p>1 yesterday; correct?</p> <p>2 A. Yes.</p> <p>3 Q. You didn't do any of these things before 4 you issued your rebuttal report; correct?</p> <p>5 A. Whenever I --</p> <p>6 Q. That's a yes or no.</p> <p>7 A. Besides my initial evaluation --</p> <p>8 Q. You didn't call Mrs. Huskey --</p> <p>9 A. I didn't. No. No.</p> <p>10 Q. Let me just get my question out. 11 You didn't call Mrs. Huskey before 12 issuing your rebuttal report --</p> <p>13 A. No.</p> <p>14 Q. -- to discuss any discrepancies between 15 Dr. Pradmudji's examination and what Mrs. Huskey 16 told you back in January; correct?</p> <p>17 A. Well, I wasn't going to be disposed, and 18 I wanted to make sure I had all of the history 19 correct.</p> <p>20 MR. SNELL: Move to strike.</p> <p>21 Nonresponsive.</p> <p>22 A. I just want to specify. I don't 23 normally call patients multiple times, but because 24 this is my first deposition, I wanted to make sure I 25 had all the answers and the most truthful and honest</p>

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<p>1 I possibly could, and provide that to you in the 2 context of my opinion as a pelvic pain specialist. 3 And whenever I said I have a couple of 4 questions about making sure that her pain was 5 resolved prior to having the mesh placed, and that 6 she was -- she'd never had a diagnosis of 7 endometriosis, and that her hysterectomy was because 8 of a fibroid and not because of intractable pelvic 9 pain or whatever it was. I wanted to make sure that 10 that was really very clear.</p> <p>11 Q. BY MR. SNELL: And these are all things 12 you did yesterday; correct?</p> <p>13 A. In addition to asking her at the time of 14 my medical exam, I wanted to make sure I was very 15 clear when I came in here and talked to you about 16 the Pradmudji report today. So I did that 17 yesterday. It was a few simple questions, and I 18 felt more confident in feeling I'm giving the 19 appropriate and correct representation. I mean, I 20 was the one who asked to see if I could speak to her 21 again.</p> <p>22 And, you know, in my own clinical 23 practice, if I have a question that may affect a 24 patient's care or an intervention or something that 25 I was going to do and I wanted clarification,</p>	<p>1 A. No. 2 Q. Did you bring any documents here today 3 to your deposition besides your rebuttal report and 4 your updated curriculum vitae, which we've now 5 marked as an exhibit? 6 A. No. 7 Q. Did you take any photographs during your 8 evaluation of Mrs. Huskey? 9 A. No. 10 Q. Were there any tests that were performed 11 during your evaluation of Mrs. Huskey? 12 A. Any diagnostic tests? 13 Q. Yes. 14 A. Well, the physical exam. 15 Q. Are there any other types of testing 16 performed during Mrs. Huskey's exam? 17 A. Are you referring to something -- I 18 guess, no. I mean, in the physical exam we perform 19 multiple tests and evaluations of her back, 20 sacroiliac joint, the vagina, the assessment of the 21 nerves of the vagina, an assessment of the -- her 22 response to pain from the vagina. I mean, all of 23 those were performed during the physical exam, but 24 as far as a diagnostic block or an invasive 25 procedure in our clinical setting, and we wouldn't</p>
<p style="text-align: center;">Page 79</p> <p>1 absolutely, I would call the patient. 2 Q. When you saw the discrepancies between 3 what you reported in your history as recited by 4 Mrs. Huskey compared to Dr. Pradmudji -- 5 A. Right. 6 Q. -- you saw those discrepancies before 7 you issued your rebuttal report, I take it? 8 A. I did. 9 Q. And did you know -- but you didn't call 10 Mrs. Huskey at that time; correct? 11 A. I didn't know it was an option. 12 Q. Did you ask anybody if it was an option? 13 A. I did not. 14 Q. Okay. Did you take any notes during 15 this conversation with Mrs. Huskey that occurred 16 yesterday? 17 A. I did not. 18 Q. Was anybody else present besides you -- 19 A. No. 20 Q. -- and Mrs. Huskey on the telephone? 21 A. No. My two-year-old was in the other 22 room. 23 Q. Have you ever corresponded with any of 24 Mrs. Huskey's medical providers, be they doctors, 25 therapists or --</p>	<p style="text-align: center;">Page 81</p> <p>1 do that normally, anyway, in a new patient setting. 2 Q. For example, there were no EMGs done on 3 her nerves; correct? 4 A. No. However, we don't -- even if I have 5 someone who has a neuropathy of the pelvis, it is 6 very difficult to assess the terminal branch of the 7 nerves that may be inflamed, which is the terminal 8 branch of the pudendal obturator, the genitofemoral. 9 So for those specifically, we didn't assess those. 10 Q. Other than the physical exam, there were 11 no types of diagnostic procedures performed on 12 Mrs. Huskey at the time of your evaluation; is that 13 correct? 14 A. Well, there were no diagnostic 15 procedures. Her physical exam was abnormal, grossly 16 abnormal. So she had a positive response to the 17 Q-Tip in the vagina, which can be a correlate of 18 increased pain sensitivity. She had a significant 19 tenderness in that left side of the vagina. There 20 was a palpable lesion on the left vaginal sidewall 21 that was painful and possible scarring or residual 22 mesh heading off to the obturator foramen. 23 I mean, it was very clear that she was 24 completely unable to have penetrative vaginal 25 intercourse that would be comfortable by any stretch</p>

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<p>1 of the imagination. While she did have pelvic floor 2 tension myalgias, we were able to place a specula 3 exam with discomfort associated. There was no 4 erosive mesh seen, but her exam was not normal. 5 6 MR. SNELL: Move to strike, 7 nonresponsive. 8 Q. BY MR. SNELL: Other than the physical 9 exam, there were no types of diagnostic procedures 10 performed on Mrs. Huskey at the time of your evaluation; is that correct? 11 A. I believe a physical exam is diagnostic. 12 We did not do any additional diagnostic procedures 13 other than a thorough physical exam. 14 Q. So that was my question. 15 Other than the physical exam that you 16 performed on Mrs. Huskey, there were no other 17 diagnostic procedures performed on Mrs. Huskey at 18 the time of your evaluation on January 11th, 2014; 19 is that correct? 20 A. Correct. 21 Q. Okay. At the time of your evaluation, 22 you did not find any evidence of erosive mesh; 23 correct? 24 A. She had scarring on the left vaginal 25 sidewall. I did not unroof that in the clinic to</p>	<p>1 that. 2 Q. BY MR. SNELL: Let me see if I can give 3 you an instruction. Perhaps this will help. 4 If I ask you a question about 5 Dr. Steege -- 6 A. Um-hum. 7 Q. -- feel free to answer it about 8 Dr. Steege. What I don't want is Dr. Steege did 9 this or that thrown into your answers because I'm 10 here deposing you. I've already deposed Dr. Steege. 11 A. Right. 12 Q. And I'm not -- if you can't answer a 13 question because you feel you have to rely on 14 Dr. Steege, that's important. Let me know that. 15 But if I'm asking you -- for example, you just 16 testified there was a palpable lesion on the left 17 side. 18 A. Right. 19 Q. You know, can you describe for me where 20 that was? 21 A. Which I did. 22 Q. Okay. But then you threw in a comment 23 about Dr. Steege found it also. 24 A. Well, I wanted to make sure -- 25 Q. I'm not interested in that.</p>
<p style="text-align: center;">Page 83</p> <p>1 find out if it was scar tissue or residual mesh. 2 Q. At the time of your evaluation on 3 January 11th, 2014, of Mrs. Huskey, she did not have 4 a mesh exposure? 5 A. No mesh exposure seen in the vagina. 6 Q. Was there any mesh erosion seen in the 7 vagina at the time you evaluated Mrs. Huskey on 8 January 11th, 2014? 9 A. No. But she had had a large mesh 10 excision procedure prior to that. 11 MR. SNELL: Move to strike after "no." 12 Q. BY MR. SNELL: This palpable lesion on 13 the left side of her vaginal wall -- 14 A. Yes. 15 Q. -- explain to me where that was. 16 A. So left vaginal sidewall. I mean, 17 basically heading out into the obturator process. 18 So you basically go around the pubic rami. I mean, 19 it was pretty -- probably 4 centimeters into the 20 vagina. Both myself and Dr. Steege were able to 21 palpate it. It reproduced her pain. I did not see 22 any mesh exposure associated with this lesion. It 23 was basically in the area of the obturator internus 24 when we did our exam. 25 MR. SNELL: I'm going to move to strike</p>	<p style="text-align: center;">Page 85</p> <p>1 A. All right. Then -- 2 MR. KUNTZ: You can answer the question 3 however you want. Don't listen to that. Answer 4 every one. 5 MR. SNELL: Jeff, you -- 6 MR. KUNTZ: No. You don't need to tell 7 her how she can answer questions, Burt. She can 8 answer whatever way she wants to. 9 MR. SNELL: Okay. That means -- look. 10 We'll be here forever then. 11 MR. KUNTZ: It's fine. You got 7 hours. 12 We'll be here. You can answer whatever you want -- 13 you can't sit here and tell her which way or not to 14 answer a question. She's been responsive. She's 15 been polite. And she's asked you to clarify when 16 you can. And when you clarified, she answered your 17 question. If Dr. Steege was there, and -- 18 MR. SNELL: I don't care if Dr. Steege 19 was there. 20 MR. KUNTZ: I don't care what you care 21 about. She can answer the question however she 22 wants. 23 MR. SNELL: I'm interested in this 24 doctor. 25 MR. KUNTZ: He was there. She's telling</p>

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<p style="text-align: center;">Page 86</p> <p>1 you the truth about what happened on that date and 2 he was there and she can answer --</p> <p>3 MR. SNELL: It has nothing to do with my 4 question. It has nothing to do with my question.</p> <p>5 MR. KUNTZ: Then ask a better question, 6 but don't sit here and lecture her --</p> <p>7 MR. SNELL: I'm not lecturing her.</p> <p>8 MR. KUNTZ: -- on how she can answer a 9 question.</p> <p>10 MR. SNELL: I'm not lecturing her at 11 all.</p> <p>12 MR. KUNTZ: Ask if she can -- okay.</p> <p>13 MR. SNELL: I'm not lecturing you. I'm 14 not interested in Dr. Steege, though.</p> <p>15 MR. KUNTZ: But he's there.</p> <p>16 MR. SNELL: I'm interested in your 17 opinions.</p> <p>18 MR. KUNTZ: He's part of the story.</p> <p>19 MR. SNELL: I don't care.</p> <p>20 MR. KUNTZ: You can't control that.</p> <p>21 MR. SNELL: Jeff, I deposed him. He is 22 not a rebuttal expert.</p> <p>23 MR. KUNTZ: That's fine.</p> <p>24 Q. BY MR. SNELL: Is Dr. Steege a rebuttal 25 expert in this case?</p>	<p style="text-align: center;">Page 88</p> <p>1 Q. What are you looking at? 2 A. This is my physical exam from the Steege 3 report.</p> <p>4 Q. Okay. Can I see what you're looking at? 5 A. You sure can.</p> <p>6 Q. Just so the record is clear, you're 7 looking at Dr. Steege's expert report and the part 8 about the physical exam?</p> <p>9 A. This is a physical exam that we 10 performed together.</p> <p>11 Q. And so Mrs. Huskey's evaluation begins 12 at page 12 of Dr. Steege's report, and the physical 13 examination you were referencing is from page 16 of 14 the report?</p> <p>15 A. Yes.</p> <p>16 Q. And there was no lesion noted in the 17 Steege report; was there?</p> <p>18 A. I'm saying lesion as far as thickening. 19 I'm using that term interchangeably.</p> <p>20 Q. Show me where on page 16 you were 21 referencing.</p> <p>22 So under the gynecologic examination on 23 page 16 of Dr. Steege's report, the second 24 paragraph, the very last sentence, which reads, 25 "Thickening of the left vaginal sidewall noted," is</p>
<p style="text-align: center;">Page 87</p> <p>1 A. No.</p> <p>2 Q. Who is the rebuttal expert in this case 3 for the plaintiffs?</p> <p>4 A. I am.</p> <p>5 Q. So I'm asking you about you and your 6 exam.</p> <p>7 A. Okay.</p> <p>8 Q. Okay. The palpable lesion on the left 9 side of Mrs. Huskey's vaginal wall that you found at 10 the time of your evaluation --</p> <p>11 A. Yes.</p> <p>12 Q. -- was approximately 4 sonometers in.</p> <p>13 A. It was approximately. I mean, I'd 14 say -- I can look at the --</p> <p>15 Q. And if you have to look at your report.</p> <p>16 A. I have to look at my report.</p> <p>17 Q. Feel free.</p> <p>18 A. Oh. So I'm just guessing because this 19 is a single digit exam which produced significant 20 tenderness behind the pubic arch. Thickening of the 21 left vaginal sidewall, mesh versus scar. And it was 22 at the level of the obturator internus. So where we 23 would go in and feel the obturator on the left 24 vaginal sidewall is where we felt that thickening 25 and scar.</p>	<p style="text-align: center;">Page 89</p> <p>1 what you were referencing?</p> <p>2 A. Yes.</p> <p>3 Q. Possible mesh versus scar?</p> <p>4 A. Correct. That reproduced her pain.</p> <p>5 Q. What was Mrs. Huskey's total vaginal 6 length at the time of your evaluation?</p> <p>7 A. It was 7 centimeters. I believe that's 8 what we found. It's from the hymenal ring to the 9 vaginal apex. And so performed without Valsalva and 10 without a speculum.</p> <p>11 Q. Okay.</p> <p>12 A. Occasionally there can be discrepancies 13 in vaginal length during the measurement, depending 14 on which apex you place a Q-Tip.</p> <p>15 Q. So you mentioned you had spent 16 approximately 50 hours on the Huskey case?</p> <p>17 A. Yes.</p> <p>18 Q. Can you break that time down for me, 19 beginning with your first work on the case?</p> <p>20 A. This will be a gross estimate, but my 21 travel and time in North Carolina, my initial visit 22 with her, the physical exam, the discussion after 23 the physical exam, the review of her medical 24 records, my individual -- or my history that I 25 shared with Dr. Steege, the review of the</p>

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<p style="text-align: center;">Page 90</p> <p>1 literature. I have not billed for any of this time. 2 I'm giving you an estimate. Approximately 10 hours 3 with my counsel for depo prep. And then my 4 preparation yesterday, including the phone call with 5 her and this morning for the deposition, including 6 the deposition.</p> <p>7 Q. Okay. So altogether -- back up. 8 For your travel time to and from North 9 Carolina, are you compensated for that?</p> <p>10 A. The -- I don't charge when I'm asleep. 11 So they covered my flight and then my time that I'm 12 working in North Carolina and my flight home. So 13 I --</p> <p>14 Q. So how many hours altogether were spent 15 in connection with you going out to North Carolina, 16 evaluating Mrs. Huskey and then returning back?</p> <p>17 A. I also saw multiple other patients 18 during that visit. But the flight, including the 19 connection, is approximately 6 hours of travel time.</p> <p>20 Q. So you saw multiple other plaintiffs 21 from the litigation --</p> <p>22 A. Yes.</p> <p>23 Q. -- at the same time as Mrs. Huskey?</p> <p>24 A. Correct.</p> <p>25 Q. And when you see multiple plaintiffs</p>	<p style="text-align: center;">Page 92</p> <p>1 A. And that was just a single time. I 2 reviewed them again yesterday.</p> <p>3 Q. The literature you -- strike that. 4 The literature review that you 5 mentioned --</p> <p>6 A. Um-hum.</p> <p>7 Q. -- when did you do that?</p> <p>8 A. I mean, I've done that throughout the 9 entire process. So I don't know how you want me to 10 allocate reading hundreds of articles or being 11 familiar with them to one patient.</p> <p>12 Q. You can't do that?</p> <p>13 A. It would be a guess, no.</p> <p>14 Q. So when you reviewed this literature, 15 it's in your connection -- strike that.</p> <p>16 When you reviewed this literature you 17 testified about, it was in connection with your role 18 as an expert for plaintiffs in multiple cases. Is 19 that correct or not?</p> <p>20 A. Correct. I reviewed additional 21 information from Mrs. Huskey.</p> <p>22 Q. What specific information or materials 23 did you review specific to Mrs. Huskey besides her 24 medical records?</p> <p>25 A. Right. Well, I've reviewed multiple</p>
<p style="text-align: center;">Page 91</p> <p>1 from litigation on the same trip, how do you 2 allocate your travel expenses? Do you break it down 3 by a fraction?</p> <p>4 A. I haven't billed for these. So I don't 5 know how I'm supposed to do that. I'm going to 6 provide my time. And then they can divide 12 hours 7 of travel time among 6 of the patients.</p> <p>8 Q. Your examination of Mrs. Huskey, 9 including talking to her, the physical --</p> <p>10 A. And then speaking with her afterwards.</p> <p>11 Q. -- and then speaking with her 12 afterwards?</p> <p>13 A. Probably 2 hours. And then not 14 including a review of her medical records.</p> <p>15 Q. That's what I'm going to get into next. 16 So your examination of Mrs. Huskey was 17 about 2 hours?</p> <p>18 A. Um-hum.</p> <p>19 Q. Is that a yes?</p> <p>20 A. Yes.</p> <p>21 Q. How long did it take you to review her 22 records?</p> <p>23 A. I did a thorough review of her records.</p> <p>24 10 to 12 hours.</p> <p>25 Q. Okay.</p>	<p style="text-align: center;">Page 93</p> <p>1 randomized controlled trials on the TTVT-O. I've 2 familiarized myself with the product. That was 3 specific to Mrs. Huskey.</p> <p>4 Q. And how --</p> <p>5 A. I reviewed --</p> <p>6 Q. Sorry. Go ahead.</p> <p>7 A. -- Dr. Pradmudji's opinions. Wrote my 8 rebuttal.</p> <p>9 Q. And so how long did it take you to write 10 your rebuttal report?</p> <p>11 A. Well, I reviewed her entire -- her 12 opinions. And so I want to say 6 hours.</p> <p>13 Q. Okay. And this literature and -- review 14 of randomized control trials, things like that, 15 you -- I think you said you couldn't really estimate 16 or break it down. So I'll move on.</p> <p>17 You had 10 hours of deposition prep 18 yesterday?</p> <p>19 A. 10 hours total.</p> <p>20 Q. Total.</p> <p>21 A. Of the depo prep. And then yesterday I 22 re-reviewed her medical records. I reviewed 23 Steege's deposition and Pradmudji's deposition. And 24 part of this is my own inexperience in providing a 25 deposition. I wanted to understand how it worked,</p>

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<p>1 and I asked to see some of them.</p> <p>2 Q. The --</p> <p>3 A. And then my day today with the</p> <p>4 deposition. So waking up, reviewing.</p> <p>5 Q. How did you prepare for the deposition?</p> <p>6 And by that I mean the 10 hours you identified.</p> <p>7 A. Um-hum.</p> <p>8 Q. What did you do? Strike that. That's a</p> <p>9 bad question.</p> <p>10 What did you do to prepare for your</p> <p>11 deposition that took you the 10 hours that you</p> <p>12 estimated?</p> <p>13 A. Went through the notice to take</p> <p>14 deposition thoroughly. I reviewed the depositions</p> <p>15 of Pradmudji and Steege. I asked really how this</p> <p>16 would go. So I wanted every detail from the</p> <p>17 beginning of the day to the end of the day. I</p> <p>18 wanted to know how you were going to ask me</p> <p>19 questions. And I -- I just had a lot of questions</p> <p>20 about this being my first deposition.</p> <p>21 Q. Who did you meet with, if anyone, to</p> <p>22 prepare for your deposition?</p> <p>23 A. I met with Jeff twice. And then I met</p> <p>24 with Margaret, Ed, and Fildelma.</p> <p>25 Q. When did you meet with Margaret, Ed, and</p>	<p>1 A. Yes.</p> <p>2 Q. And that contains all of your opinions</p> <p>3 in this case; correct?</p> <p>4 A. Correct.</p> <p>5 Q. When you saw Mrs. Huskey on</p> <p>6 January 11th, 2014, was her husband also present in</p> <p>7 the room at the time of your history?</p> <p>8 A. I don't believe so, no.</p> <p>9 Q. Was Mrs. Huskey's husband present at the</p> <p>10 time of your examination of Mrs. Huskey?</p> <p>11 A. No.</p> <p>12 Q. Do you recall if he was -- strike that.</p> <p>13 Do you recall Mr. Huskey was present at</p> <p>14 all on January 11th, 2014?</p> <p>15 A. I don't remember seeing him.</p> <p>16 Q. You don't remember talking to him at</p> <p>17 all?</p> <p>18 A. No.</p> <p>19 Q. Do you have a recollection of ever</p> <p>20 speaking to Mr. Huskey?</p> <p>21 A. No. No. Hum-um. I really don't</p> <p>22 remember.</p> <p>23 Q. When did you first review</p> <p>24 Dr. Pradmudji's deposition?</p> <p>25 A. Her deposition or her opinions?</p>
<p style="text-align: center;">Page 95</p> <p>1 Fildelma.</p> <p>2 A. Was that the 17th of June or July?</p> <p>3 June. I don't remember.</p> <p>4 Q. Can't be July.</p> <p>5 A. Can't be July. Definitely June. I</p> <p>6 believe it was the 17th of June.</p> <p>7 Q. And that was about the Huskey case?</p> <p>8 A. Yes.</p> <p>9 Q. And you met with Mr. Kuntz twice to</p> <p>10 prepare for the Huskey case?</p> <p>11 A. Yes.</p> <p>12 Q. Are you currently under a deposition</p> <p>13 notice or schedule to testify --</p> <p>14 A. No.</p> <p>15 Q. -- in any other litigation cases?</p> <p>16 A. No.</p> <p>17 MR. SNELL: Let's take a break.</p> <p>18 (Recessed from 11:46 a.m. to</p> <p>19 12:08 p.m.)</p> <p>20 Q. BY MR. SNELL: Back on the record.</p> <p>21 Exhibit 2 we marked as your rebuttal</p> <p>22 expert report.</p> <p>23 A. Yes.</p> <p>24 Q. And that's your final expert report in</p> <p>25 this case; correct?</p>	<p style="text-align: center;">Page 97</p> <p>1 Q. Her deposition.</p> <p>2 A. Deposition. I reviewed it yesterday.</p> <p>3 Q. When did you first review</p> <p>4 Dr. Pradmudji's expert report?</p> <p>5 A. I reviewed her report in mid-April,</p> <p>6 whenever it was emailed to me.</p> <p>7 Q. When did you first review</p> <p>8 Dr. Pradmudji's report regarding her independent</p> <p>9 medical examination of Mrs. Huskey?</p> <p>10 A. Is that separate from her opinion? I</p> <p>11 don't know if I received that.</p> <p>12 MR. SNELL: I'll go ahead and mark it</p> <p>13 just so we're clear.</p> <p>14 THE WITNESS: Sure.</p> <p>15 (Exhibit 4 marked.)</p> <p>16 Q. BY MR. SNELL: Doctor, I've handed you</p> <p>17 Exhibit No. 4, which I'll represent is</p> <p>18 Dr. Pradmudji's IME examination for Mrs. Huskey</p> <p>19 which was performed April 11th.</p> <p>20 Have you seen this document before?</p> <p>21 A. Yes, I have.</p> <p>22 Q. Okay. When did you first see</p> <p>23 Dr. Pradmudji's IME report concerning Mrs. Huskey?</p> <p>24 A. Definitely after April 11th. I can't</p> <p>25 tell you the exact date, but I have seen it.</p>

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<p>1 Q. Did you see Dr. Pradmudji's IME report 2 in preparation for your deposition? 3 A. Not specifically. 4 Q. Do you know if you had read 5 Dr. Pradmudji's IME report of Mrs. Huskey before you 6 issued your rebuttal report on April 11th, 2014? 7 A. I believe I did. 8 Q. Would you have letters of transmittal or 9 emails that show when you receive certain case 10 materials, including medical records and reports? 11 A. That would be easier than my memory to 12 document, yes. 13 Q. So I'll ask -- 14 A. That's fine. 15 Q. -- that the letters of transmittal and 16 the emails providing you with Huskey case materials 17 from the outset of reports, medical records, 18 depositions be provided, be produced. 19 A. Yes. 20 Q. Those will be a more accurate recitation 21 of the time when you received these materials than 22 your recollection today? 23 A. Agreed. Yes. 24 Q. The medical literature, the randomized 25 control trials you looked at in connection with</p>	<p>1 MR. KUNTZ: It's all electronic. 2 A. It's all electronic. 3 MR. KUNTZ: I can get you everything we 4 sent her. 5 A. Like the medical records and then the -- 6 Q. BY MR. SNELL: Yeah. One of the things 7 we asked be produced at this deposition is your case 8 file on Mrs. Huskey. 9 A. Okay. 10 Q. So have you made any notes or notations 11 or highlighting, any -- any type of writings on her 12 records or any of the literature -- 13 A. No. 14 Q. -- or the documents you reviewed? 15 A. Everything was electronic. So the only 16 additional writing I wrote was the creation of the 17 rebuttal. 18 Q. Okay. Before you saw Mrs. Huskey on -- 19 A. January 11th. 20 Q. -- January 11th, 2014, what, if 21 anything, did you know about her? 22 A. I knew nothing about her. 23 Q. Am I correct then that Dr. Steege had 24 not provided you with an overview of what her 25 medical or surgical history was before you went in</p>
<p style="text-align: center;">Page 99</p> <p>1 Mrs. Huskey's case -- 2 A. Um-hum. 3 Q. -- how did you receive those articles? 4 A. It was a compilation of my own 5 literature search, as well as the ones -- articles 6 that have been provided to me in a database. 7 Q. What's the database where these articles 8 are provided to you? 9 A. It's an email or emailed into a drop box 10 with access to literature pertaining to mesh. 11 Q. Do you have all the materials that you 12 reviewed here with your deposition? 13 A. No. 14 Q. You didn't bring your case file for 15 Mrs. Huskey? 16 A. Not my specific case file, I do not. 17 Q. Okay. Is there any way you can get 18 that? 19 A. All of the -- a list of all the articles 20 I reviewed. 21 Q. No. I mean your actual case file. The 22 records you looked at, the literature, you know, 23 whatever your Huskey case file would be. 24 A. I think it -- 25 Q. Can we get it here today?</p>	<p style="text-align: center;">Page 101</p> <p>1 to do your history of her? 2 A. Correct. We did not discuss that. 3 Q. So essentially you went in to take your 4 history from Mrs. Huskey cold, without any 5 information or knowledge about her? 6 A. Yes. 7 Q. And you relied on what she told you? 8 A. No. I mean, I used the combination of 9 the information I queried her on during her history. 10 Q. Um-hum. 11 A. And then as well as the -- her medical 12 records. 13 So as far as exact specific dates of 14 procedures, I referred to her medical records. 15 But she appeared to me to be a thorough 16 and appropriate historian and was able to provide at 17 least her -- every detailed report of her pain since 18 the excisional mesh procedure. 19 Q. What about her pain that predated her 20 mesh insertion? Did she bring you a thorough 21 history of that? 22 MR. KUNTZ: Objection. You can answer. 23 Q. BY MR. SNELL: You can answer. 24 A. Okay. Sorry. 25 She -- we -- so very specifically,</p>

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<p>1 because this is -- very specifically I asked if she 2 had any episodes of sexual-related pain prior to the 3 mesh placement that were similar to the pain she 4 complained of at her present interview in January. 5 She gave a detailed report of her experience in 6 November and December of the previous fall. She 7 noted resolution of her left lower quadrant pain and 8 suprapubic pain, following her colonoscopy prep when 9 she was hospitalized. She said that for some reason 10 that had resolved her pain.</p> <p>11 She reported that she had had previous 12 urinary tract infections that had been treated and 13 the pain was resolved. And overall she reported 14 that she had a fulfilling and non-painful sexual 15 relationship with her husband.</p> <p>16 Q. BY MR. SNELL: At the time you took your 17 history, though, you didn't have a grasp on those 18 medical records to know whether she was being 19 accurate or truthful; correct?</p> <p>20 A. I mean, she was a good historian. So I 21 believe that she was being truthful.</p> <p>22 Q. You accepted what she told you at the 23 time of your history you took from her in January of 24 2014; correct?</p> <p>25 A. I did.</p>	<p>1 Q. -- involved, can you add that in? 2 A. Sure. So a normal week, I am considered 3 100 percent clinical. Though I do have a full day 4 of administration time. So I have 80 percent 5 hands-on patient care throughout the week. Monday, 6 I have my GYN pain clinic in the morning and in the 7 afternoon.</p> <p>8 Tuesday I'm in the operating room. 9 Wednesday morning, I have a half day of 10 administration time. Wednesday afternoon I have a 11 clinic.</p> <p>12 Thursday morning, I have a clinic. 13 Thursday afternoon I have administration time. 14 And Friday I'm in the operating room. 15 I do provide lectures to the residents 16 occasionally during their didactic period, which is 17 Friday afternoon, although because this lands on 18 my -- during my operating schedule, it occurs once 19 every few months. I also am a clinical teacher, so 20 I routinely have some -- a learner in my clinic, 21 such as a medical student, a resident, a visiting 22 professor, and do a lot of hands-on teaching at that 23 time. I travel nationally and internationally and 24 speak on pelvic pain.</p> <p>25 Q. The clinic you do on Wednesday</p>
<p style="text-align: center;">Page 103</p> <p>1 Q. And you hadn't had the benefit of having 2 seen her and reviewed her records in detail before 3 seeing her, such that if there were any 4 discrepancies, you could query her about those; 5 correct?</p> <p>6 A. Correct. Discrepancies regarding the 7 dates, I did. I can't recall specifically if there 8 were any, but I definitely would resort to the 9 medical record. I reviewed the medical record, 10 though, shortly after seeing her, during my time in 11 North Carolina. So it would be a way I would 12 normally put together a detailed history and 13 physical examination of a patient I would see in a 14 clinic.</p> <p>15 Q. What percent of your time in your 16 practice is spent treating patients?</p> <p>17 A. I am a clinical practitioner. So all of 18 my time. Do you want a breakdown of my week?</p> <p>19 Q. Yeah. Let's do that. Maybe that's a 20 little better.</p> <p>21 A. Be easier to --</p> <p>22 Q. That's no problem.</p> <p>23 So can you tell me about your normal 24 week, and if there's teaching or lecturing --</p> <p>25 A. Okay.</p>	<p style="text-align: center;">Page 105</p> <p>1 afternoon, which clinic is that? 2 A. It's the same clinic I have every day. 3 So it's a gynecology only pain clinic.</p> <p>4 Q. Okay. And that would be the same clinic 5 as you do for the half day on Thursday as well?</p> <p>6 A. Yes. I do see about 80 -- I do see some 7 routine GYN patients. But the majority of practice 8 is -- is pain based.</p> <p>9 Q. Okay. And when you do your surgery, 10 where's that at?</p> <p>11 A. On Tuesdays I'm primarily at the pain 12 campus at University of Kansas. On Fridays, I'm 13 primarily at an off-site hospital. Indian Creek 14 campus. I do minor, more minor procedures there.</p> <p>15 Q. The Indian Creek campus, though, is an 16 affiliate or is a part of the university campus?</p> <p>17 A. It is part of the university. It's just 18 another hospital.</p> <p>19 Q. What percent of your time is spent on 20 litigation matters?</p> <p>21 A. A very small percent. So it would be in 22 my -- the hours I provided for the Huskey case, a 23 small amount of travel outside of that for the 24 independent medical exams, but it is in my off time.</p> <p>25 Q. Did you review any Ethicon company</p>

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<p>1 documents in connection with formulating your 2 opinions?</p> <p>3 A. Such as? I mean, I haven't been to the 4 web site and searched for any additional documents.</p> <p>5 Q. Did you --</p> <p>6 A. I did read the IFU. I'm familiar with 7 it.</p> <p>8 Q. I take it you mean the IFU for the 9 TTVT-O?</p> <p>10 A. Yes.</p> <p>11 Q. Did you review the IFU for the TTVT-O 12 before you issued your rebuttal report or sometime 13 after?</p> <p>14 A. I reviewed that in the process of this 15 whole thing. I think it was before. I specifically 16 reviewed that since.</p> <p>17 Q. Did you review any other Ethicon 18 documents regarding the TTVT-O?</p> <p>19 A. No.</p> <p>20 Q. In formulating your report and opinions 21 that you've memorialized in your expert report 22 that's been marked as Exhibit 2 --</p> <p>23 A. Um-hum.</p> <p>24 Q. -- am I correct that the bases or 25 sources of your opinions and information come from</p>	<p>1 very broad.</p> <p>2 A. Yeah. It's broad.</p> <p>3 Q. That's how depositions work, and then 4 I'll listen to you, and it may spur more questions. 5 So let me just kind of clean it up and then ask a 6 question.</p> <p>7 A. Yeah. Um-hum.</p> <p>8 Q. What involvement, if any, did you have 9 in the drafting and finalization of Dr. Steege's 10 expert report?</p> <p>11 A. So in addition to both of us writing up 12 our individual histories of the patients, our 13 combined medical exam, both of us contributed to the 14 report. We both drafted and added our pieces. And, 15 I mean, really both edited it so that we didn't have 16 too much duplicity of information. So --</p> <p>17 Q. Is it your standard practice in these 18 litigation matters to both draft and edit 19 Dr. Steege's reports that are submitted under his 20 name in his expert report?</p> <p>21 A. These were designed to be from both of 22 us. So I mean we both interviewed the patients. We 23 both examined the patients and we both contributed 24 to the report.</p> <p>25 So I guess I don't know how these things</p>
<p style="text-align: center;">Page 107</p> <p>1 your evaluation and examination of Mrs. Huskey, her 2 medical records, the TTVT-O IFU, the medical 3 literature that was given to you and that you 4 searched on your own, and that's it?</p> <p>5 A. In response to Dr. Pradmudji's opinion, 6 yes. That's correct.</p> <p>7 Q. Is there any other documents or 8 categories of information you considered in forming 9 opinions?</p> <p>10 A. No.</p> <p>11 Q. Okay. Have you ever met Dr. Pradmudji?</p> <p>12 A. No.</p> <p>13 Q. Did you review any of the other expert 14 reports besides Dr. Pradmudji's report that were 15 submitted on behalf of Ethicon?</p> <p>16 A. I don't believe so.</p> <p>17 Q. What was your involvement in the 18 drafting and finalization of Dr. Steege's expert 19 report in the Huskey case?</p> <p>20 A. As far as we wrote the report together? 21 Is that what you're asking? Did we write the report 22 together.</p> <p>23 Q. What was your involvement?</p> <p>24 A. Okay.</p> <p>25 Q. So my question is very basic and it's</p>	<p style="text-align: center;">Page 109</p> <p>1 normally or usually work, but this is my first 2 experience with independent medical exam, and that's 3 how we did this was together, with my mentor. We 4 both have additional and unique training when it 5 comes to these women who have very specific sexual 6 health complaints. And I think it makes the report 7 stronger that both of our evaluations are provided.</p> <p>8 I mean also we were instructed to give 9 one assessment, not two individual evaluations. So 10 for this, this was a very usual thing that we did 11 for all of our patients. We evaluated.</p> <p>12 In a typical clinical setting, it's just 13 not feasible.</p> <p>14 Q. You and Dr. Steege were instructed to 15 give one assessment; is that right?</p> <p>16 A. To write one medical exam. We both 17 entered it. We both edited. It's both of our 18 opinions. But that's not necessarily why I'm 19 brought into this case. I know that you've -- as 20 you've said, you've deposed Dr. Steege, and my 21 contribution is the rebuttal for Dr. Pradmudji.</p> <p>22 Q. Are you licensed here in Missouri?</p> <p>23 A. No. Kansas. I don't have a Missouri 24 license.</p> <p>25 Q. I'm confused.</p>

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<p>1 A. I know it's very confusing.</p> <p>2 Q. I'm confused because we're here in</p> <p>3 Kansas City.</p> <p>4 A. I know.</p> <p>5 Q. Forgive my geographic confusion.</p> <p>6 You're licensed to practice medicine in</p> <p>7 Kansas; correct?</p> <p>8 A. Correct. I have also maintained my</p> <p>9 license in North Carolina.</p> <p>10 Q. So your North Carolina license is still</p> <p>11 current?</p> <p>12 A. It's still current.</p> <p>13 Q. When you took your Ob/Gyn boards, did</p> <p>14 you pass them the first time?</p> <p>15 A. I did.</p> <p>16 Q. Are there any subspecialty board</p> <p>17 certifications or any other board certifications</p> <p>18 that you've ever sat for?</p> <p>19 A. No.</p> <p>20 Q. Any that you're intending on taking in</p> <p>21 the future?</p> <p>22 A. As soon as I hurry up and write one for</p> <p>23 laparoscopy, I'll sit for those. And I have</p> <p>24 considered sitting for pain medicine boards. I just</p> <p>25 needed to complete my general boards first.</p>	<p>1 writing publications?</p> <p>2 A. It was very heavy clinically. So we</p> <p>3 were in the operating room at least three days a</p> <p>4 week. We had a clinical volume load of at least</p> <p>5 three half days of clinic a week. I also completed</p> <p>6 in the fellowship -- you complete a master's of</p> <p>7 science in clinical research, which is during that</p> <p>8 time. And, unfortunately, the way it worked out,</p> <p>9 our clinical load is such that a lot of our research</p> <p>10 time was also done in the evenings and on the</p> <p>11 weekends. I was also affiliated with and had the</p> <p>12 opportunity to work with the Center for Neurosensory</p> <p>13 Disorders there, and I continue to work with them.</p> <p>14 That's been some of my dysmenorrhea research, and</p> <p>15 continue to collaborate with many people that I met</p> <p>16 during my time in North Carolina.</p> <p>17 Q. And then after that, that's when you did</p> <p>18 the anesthesia?</p> <p>19 A. I did the anesthesia focus, GYN pain.</p> <p>20 Q. And how was your time allocated there?</p> <p>21 You testified about 25 percent was research and</p> <p>22 articles. What was the other 75 percent?</p> <p>23 A. So it was clinically my day -- my week</p> <p>24 was -- I was -- half the week I was an anesthesia</p> <p>25 fellow, and half the week I was a GYN attending.</p>
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<p>1 Q. What percent of your time is spent doing</p> <p>2 research and writing publications and articles? And</p> <p>3 I just want to talk about for the last two years?</p> <p>4 A. The last two years?</p> <p>5 Q. Yes.</p> <p>6 A. It's been very different. I was in a</p> <p>7 fellowship my last year in North Carolina. So it</p> <p>8 was very heavy. I mean, I had 20, 25 percent of my</p> <p>9 time was busy with research.</p> <p>10 Since transitioning to a very busy</p> <p>11 clinical practice, it's my own time. And so I do it</p> <p>12 in the evenings, on weekends. Not unusual for</p> <p>13 people with a very heavy clinical volume.</p> <p>14 Q. Okay. When you were doing your</p> <p>15 fellowship --</p> <p>16 A. Um-hum.</p> <p>17 Q. -- was that under Dr. Steege?</p> <p>18 A. My first fellowship, yes, Dr. Steege and</p> <p>19 Dr. Zolnoun and Dr. Siedhoff.</p> <p>20 Q. That was the advanced laparoscopy and</p> <p>21 pelvic pain; correct?</p> <p>22 A. Yes.</p> <p>23 Q. When you did that fellowship, can you</p> <p>24 tell me how was your time allocated between</p> <p>25 clinical, administrative, and other duties like</p>	<p>1 That means I would -- I did some surgical</p> <p>2 procedures, but because of my clinical volume with</p> <p>3 the other two pain practices, I was limited in the</p> <p>4 operating room. I had three half days of pain</p> <p>5 clinic, a full day of pain anesthesia procedures,</p> <p>6 usually a full day of surgery, and then research, I</p> <p>7 participated in a mesh pain clinic during that time.</p> <p>8 Q. The mesh pain clinic --</p> <p>9 A. Was during that year.</p> <p>10 Q. What year is this?</p> <p>11 A. 2013. That's when it was initiated.</p> <p>12 Q. Okay. When in 2013?</p> <p>13 A. I don't know the exact date, but it</p> <p>14 was -- it was --</p> <p>15 Q. Do you remember if it was winter?</p> <p>16 spring? summer? fall?</p> <p>17 A. Beginning -- I probably say it was like</p> <p>18 winter or spring of 2013 is when it kind of started</p> <p>19 getting -- or when it started being initiated. I</p> <p>20 don't have the exact dates.</p> <p>21 Q. That's fine. So in the winter or spring</p> <p>22 of 2013 you began working?</p> <p>23 A. I was still a fellow. During my</p> <p>24 fellowship, whenever I was with Dr. Zolnoun, she did</p> <p>25 a large volume of vulvar mesh patients in pain</p>

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<p>1 clinic. So it was collaboration between her and 2 some of the urogynecologists to make the mesh pain 3 clinic.</p> <p>4 Q. So your best recollection is the mesh 5 pain clinic was started around the winter or spring 6 of 2013?</p> <p>7 A. Estimate, yes.</p> <p>8 Q. And that would have been about the time 9 you would have begun working there?</p> <p>10 A. Transitioning from my fellowship to 11 another additional training.</p> <p>12 Q. How often did you work in that mesh pain 13 clinic?</p> <p>14 A. Whenever I was a fellow, I was available 15 on the Monday afternoons that it was run.</p> <p>16 Whenever I did my additional fellowship, 17 I often would -- I probably made it once a month to 18 the clinic because of my other pain duties. But 19 still, I mean every clinic was six plus patients and 20 it would go into the evenings. And there were two 21 providers, one from urogynecology, one from our pain 22 clinic. It was a pretty -- pretty busy place.</p> <p>23 Q. Was Dr. Steege --</p> <p>24 A. No.</p> <p>25 Q. -- involved in the mesh pain clinic at</p>	<p>1 those articles that you searched and found.</p> <p>2 A. Yeah.</p> <p>3 Q. I know, you know -- did you download 4 them to your bibliography on PubMed, or would you 5 have just kept them on the clipboard?</p> <p>6 A. No. I would have kept them. I can 7 look. I have to go back to April.</p> <p>8 Q. If you have those or can locate those, 9 please, let Mr. Kuntz know?</p> <p>10 MR. KUNTZ: Yeah.</p> <p>11 MR. SNELL: I think. Let's take a lunch 12 break. It's 12:40.</p> <p>13 THE WITNESS: Okay. That sounds good. (Recessed from 12:41 p.m. to 14 1:39 p.m.)</p> <p>15 Q. BY MR. SNELL: All right. Doctor, we're 16 back from a lunch break. Are you ready to proceed?</p> <p>17 A. I am. Thanks.</p> <p>18 Q. You mentioned that you had obviously had 19 involvement in the drafting, and you had seen 20 Dr. Steege's expert report.</p> <p>21 My question is: Have you seen any other 22 expert report by any of the other plaintiff's 23 experts?</p> <p>24 A. I mean, I think I have. I don't know</p>
<p style="text-align: center;">Page 115</p> <p>1 all?</p> <p>2 A. No. He was not.</p> <p>3 Q. Do you have any copies of the searches 4 you did to locate the medical literature that you're 5 relying upon for your opinions?</p> <p>6 A. Do I have copies of the searches I did? 7 Whatever I included in -- as far as referenced, I 8 may have them on my PubMed database. Sometimes I 9 make a clipboard or a file.</p> <p>10 Q. Right.</p> <p>11 A. So I can look. I don't have it off the 12 top of my head, but I often do that whenever I am 13 doing some research.</p> <p>14 Q. Right. PubMed has some ability you can 15 sort and download and put on your clipboard or 16 e-file?</p> <p>17 A. You have to make sure you move it off 18 the clipboard or it erases. So I've learned that 19 once or twice.</p> <p>20 Q. So PubMed is the search engine you would 21 use to do research?</p> <p>22 A. Yes. Yes.</p> <p>23 Q. Medical research?</p> <p>24 A. Correct.</p> <p>25 Q. If you can check and see if you have</p>	<p style="text-align: center;">Page 117</p> <p>1 the specific names. I think they've been provided, 2 but I don't know if I actually read them or went 3 into detail with them.</p> <p>4 Q. You testified you read Dr. Steege's 5 deposition; correct?</p> <p>6 A. Correct.</p> <p>7 Q. Did you read any of the other 8 depositions of the plaintiff's experts?</p> <p>9 A. They were -- there was a couple that 10 were provided. I asked for Rosenzweig's. I did not 11 read that, but I had it available to me. And 12 there -- I think a couple more were provided. The 13 only ones I read were Steege's and Pradmudji.</p> <p>14 Q. Have you had any communications with any 15 of the plaintiff's experts?</p> <p>16 A. No.</p> <p>17 Q. Have you exchanged any emails, written 18 communication with any of the plaintiff's experts?</p> <p>19 A. No.</p> <p>20 Q. Dr. Iakovlev is a pathologist?</p> <p>21 A. He is.</p> <p>22 Q. He's one of the plaintiff's experts?</p> <p>23 A. Oh, I didn't consider him as one of the 24 experts. I know him just from a collaborative research.</p>

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1 Q. You didn't read his report or 2 deposition? 3 A. No. But I had emailed with him. 4 Q. About what? 5 A. About a project we had worked on 6 together. An abstract that was submitted called The 7 Pathology of Explanted Vaginal Mesh. 8 Q. There's no pathology in Mrs. Huskey's 9 case. You're aware of that? 10 A. I'm -- I don't believe that it was 11 included in our manuscript; correct. 12 Q. The abstract publications on this 13 project, did you bring them to the deposition today? 14 A. They're available. 15 THE WITNESS: Do you have that? 16 MR. KUNTZ: Yeah. I thought they were 17 sent to you. Can we go off the record for a second. 18 (Discussion off the record.) 19 Q. BY MR. SNELL: You mentioned 20 Dr. Rosenzweig. Do you know him? 21 A. No. 22 Q. You never met him? 23 A. No. 24 Q. Have you ever met Dr. Iakovlev? 25 A. No.	1 If a patient has pain, it would -- I mean, I would 2 ask them if they could put it on a scale. It tries 3 to -- what you're trying to do is provide some kind 4 of measurement to guide the severity of pain and the 5 distress it causes the patient. 6 Q. Can pelvic examinations of a patient who 7 has pain exacerbate their pain? 8 A. If they have pelvic or vaginal pain, 9 yes. 10 Q. You have your rebuttal report in front 11 of you? 12 A. I do. You want me to look at something? 13 Q. Yeah. Let's go to the second page where 14 you set forth the rebuttal opinion No. 1 regarding 15 Dr. Pradmudji's opinion that Mrs. Huskey's levator 16 spasm is not caused by the TVT-O because it is not 17 in the same location. 18 Are you there? 19 A. Um-hum. I see that. 20 Q. You write in the first sentence -- and 21 I'm going to move towards the end of it -- that "the 22 vaginal pain appeared posterior to Dr. Pradmudji." 23 A. Um-hum. 24 Q. Correct? 25 A. Yes.
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1 Q. Can a patient's pain levels change day 2 to day? 3 A. Their perception of pain can be 4 different day to day, yes. 5 Q. Is that something you see in some of 6 your patients, even week to week that their pain 7 perception changes? 8 A. Pain's affected by many things. So, 9 yeah, it can be -- I mean, can their reported pain 10 level be different day to day? I mean -- is that 11 what you're asking? 12 Q. Yes. 13 A. Yes. 14 Q. Pain is a subjective complaint? 15 A. It is. It's considered the fifth vital 16 sign that we use to assess patients. 17 Q. When you ask patients about their pain 18 levels, do you use scales like rated out of a 1 to 19 10, 10 being the worst, 1 being no pain. 20 Do you use any methodology like that? 21 A. It's one way to evaluate the severity of 22 pain. 23 Q. Is that something you employ in your 24 practice? 25 A. Not consistently, but sometimes, yes.	1 Q. Okay. Do you agree or disagree with 2 that location of being a posterior pain? 3 A. Which pain? 4 Q. The posterior pain that Dr. Pradmudji 5 noted. 6 A. I mean, even I noted that on her exam. 7 She has levator muscle spasm, but that's part of 8 pelvic floor tension myalgias, but that's not 9 necessarily -- that's not the exact -- that's not 10 the same pain as the left vaginal wall pain that she 11 feels during intercourse. But with palpation, that 12 was consistent with my exam also. She had some 13 tenderness of the levator muscle. 14 Q. What I'm trying to understand is the 15 vaginal pain that Dr. Pradmudji noted being 16 posterior, do you agree or disagree with that? 17 A. She does have vaginal pain posterior in 18 addition to her mesh-related pain. 19 What my opinion was here was that 20 Dr. Pradmudji said that her spasm was not caused at 21 all by the mesh procedure, and I think that's 22 incorrect. 23 Q. And where you say the spasm is occurring 24 in the entire pelvic floor muscular, that's what 25 you're talking about?

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<p>1 A. Yes. Um-hum.</p> <p>2 Q. What was that based on?</p> <p>3 A. That's how these muscles work. I mean,</p> <p>4 very -- so the levator muscle complex is not just --</p> <p>5 it's not like pointing to the bicep where you say</p> <p>6 that's exactly where your pain is. It's an entire</p> <p>7 dome of muscles that are in the pelvis that help</p> <p>8 support all of the pelvic structures.</p> <p>9 Yes, she has some posterior tenderness.</p> <p>10 Just because -- the vagina is a tube. Just because</p> <p>11 you have pain here -- that means that whole muscular</p> <p>12 tube -- doesn't mean that can't be caused from</p> <p>13 something from the left vaginal sidewall. Can be</p> <p>14 caused by the interior, the bladder, the bowel. I</p> <p>15 mean, all those things can cause this entire complex</p> <p>16 to spasm. So just saying that someone has a little</p> <p>17 bit of posterior pain here, you cannot conclude that</p> <p>18 it wasn't caused by something that happened here or</p> <p>19 scarring or injury. I mean, this is not that far</p> <p>20 away. This is -- the way these muscles work is a</p> <p>21 contracture in response to irritation or pain or</p> <p>22 injury.</p> <p>23 Does that make sense?</p> <p>24 Q. Well, the pelvic muscles can contract</p> <p>25 for numerous reasons beyond those you just</p>	<p>1 Q. She's a therapist?</p> <p>2 A. She's a physiatrist.</p> <p>3 Q. Did you ask for all of the depositions</p> <p>4 of Mrs. Huskey's treating doctors?</p> <p>5 A. Whatever was not in the medical record,</p> <p>6 I didn't ask for anything additional except for some</p> <p>7 depositions to read prior to my own. So I'm not</p> <p>8 sure if I received all of them, but I did not read</p> <p>9 them if I did.</p> <p>10 Q. Okay. So you don't know what</p> <p>11 Dr. Siddique testified to about when the mesh</p> <p>12 retracted behind the pubic bone?</p> <p>13 A. I know it was in his operative report</p> <p>14 and what he described. So, you know, the mesh -- in</p> <p>15 his excision of the mesh to the vaginal sidewall.</p> <p>16 So I know he did not completely excise the mesh, and</p> <p>17 there was an extensive procedure. But he was able</p> <p>18 to get a large portion of it out, and that was just</p> <p>19 described from his operative report.</p> <p>20 Q. Beyond the operative report, though, you</p> <p>21 don't know anything about Dr. Siddique and what he</p> <p>22 saw?</p> <p>23 A. I mean, the operative report is a pretty</p> <p>24 good description of what occurred during the</p> <p>25 surgery. But I didn't see anything else. I mean, I</p>
<p style="text-align: center;">Page 123</p> <p>1 elicited -- enumerated; correct?</p> <p>2 A. They can.</p> <p>3 Q. When I -- the spasm, you opine, which is</p> <p>4 occurring in the entire pelvic floor musculature,</p> <p>5 that's based on your January 2014 examination of</p> <p>6 Mrs. Huskey?</p> <p>7 A. Yes.</p> <p>8 Q. Turn to the next page at the top where</p> <p>9 you talk about Dr. Siddique's operative report.</p> <p>10 A. Um-hum. I see that.</p> <p>11 Q. And the mesh was dissected up the</p> <p>12 vaginal sidewall, and you note retracting behind the</p> <p>13 pubic bone.</p> <p>14 Are you there with me?</p> <p>15 A. I am.</p> <p>16 Q. Did you read Dr. Siddique's testimony</p> <p>17 about that retracting behind the pubic bone?</p> <p>18 A. I only read what was in his operative</p> <p>19 report.</p> <p>20 Q. You haven't read Dr. Siddique's</p> <p>21 deposition?</p> <p>22 A. No.</p> <p>23 Q. Have you read any of the deposition of</p> <p>24 any of Mrs. Huskey's treating doctors?</p> <p>25 A. I did look at Colleen Fitzgerald's.</p>	<p style="text-align: center;">Page 125</p> <p>1 didn't read any additional description of what</p> <p>2 occurred.</p> <p>3 Q. When did you get Dr. Fitzgerald's</p> <p>4 deposition?</p> <p>5 A. I have to look at my email. I can</p> <p>6 provide that for you.</p> <p>7 Q. Do you know if it was before or after</p> <p>8 you did your rebuttal report?</p> <p>9 A. Oh, it was after. It was whenever I was</p> <p>10 assigned a date for the deposition.</p> <p>11 Q. A little further under there you talk</p> <p>12 about Dr. Pradmudji, and you take a quote out of her</p> <p>13 deposition where it says, "I'd have to look at the</p> <p>14 anatomy book because I don't have it memorized."</p> <p>15 Do you see where I'm at?</p> <p>16 A. I do.</p> <p>17 Q. And did you read Dr. Pradmudji's entire</p> <p>18 deposition?</p> <p>19 A. Not every word.</p> <p>20 Q. Do you know if Dr. Pradmudji testified</p> <p>21 anywhere else in her deposition about the different</p> <p>22 pelvic floor muscles?</p> <p>23 A. I don't know all of the details.</p> <p>24 Q. What was your methodology for picking</p> <p>25 out one quote out of a 200-plus page deposition?</p>

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<p>1 A. I just thought it was kind of a -- if 2 she's going to make a conclusion about a levator ani 3 complex and make it one of her formal expert 4 opinions but then couldn't describe what muscles 5 lined the transobturator canal or foramen or how the 6 levator muscles work in relation to the obturator 7 and obturator internus, it just kind of surprised 8 me.</p> <p>9 Q. Let me see if I understand this. 10 Is it your testimony that Dr. Pradmudji 11 doesn't know the muscles in the pelvic floor or 12 around the transobturator area, and she didn't 13 testify about that in her deposition?</p> <p>14 A. No.</p> <p>15 MR. KUNTZ: Objection.</p> <p>16 Q. BY MR. SNELL: You're aware she 17 testified about the different muscles in her 18 deposition; correct?</p> <p>19 A. I would have to look at her deposition. 20 I know she did discuss her pelvic floor muscles. I 21 just said it's really interesting how she doesn't 22 think the levator ani spasm could be caused from the 23 transobturator tape, which goes through where the 24 levator ani actually inserts, one of the insertion 25 points -- how that would be related in any way,</p>	<p>1 don't -- I don't know if she was wearing it whenever 2 I saw her.</p> <p>3 Q. And are compliance with -- strike that. 4 Can a patient's compliance with wearing 5 their SI brace effect their SI pain levels?</p> <p>6 A. Their SI joint pain may -- if it makes 7 her pain better, then it might do that.</p> <p>8 Q. What's your understanding of the effect 9 that her SI brace had on her pain?</p> <p>10 MR. KUNTZ: Objection.</p> <p>11 A. I'm assuming she had a brace and she 12 wore it. She would only wear it if it was effective 13 or at least reduce some of her pain. Now --</p> <p>14 Q. BY MR. SNELL: Did you ask her during 15 your history of her when she had been first 16 prescribed that SI brace?</p> <p>17 A. I don't recall.</p> <p>18 Q. Did you ask her how often she wore her 19 SI brace within the week before she saw you and you 20 evaluated her?</p> <p>21 A. The SI joint is a major weightbearing 22 joint in the pelvis or the --</p> <p>23 MR. SNELL: I'm going to move to strike.</p> <p>24 A. But --</p> <p>25 Q. BY MR. SNELL: My question was about the</p>
<p style="text-align: center;">Page 127</p> <p>1 shape, or form. It just surprised me.</p> <p>2 Q. You believe that Mrs. Huskey had levator 3 ani spasm?</p> <p>4 A. She does.</p> <p>5 Q. Dr. Pradmudji believes she has those 6 spasms.</p> <p>7 A. That are not caused by the mesh. That's 8 where we disagree.</p> <p>9 Q. So you both agree that there are levator 10 ani spasms, but you disagree as to the cause; fair?</p> <p>11 A. That is fair.</p> <p>12 Q. Mrs. Huskey has SI joint dysfunction; 13 correct?</p> <p>14 A. She does.</p> <p>15 Q. She's had that even before her mesh was 16 put in; correct?</p> <p>17 A. Correct.</p> <p>18 Q. Was she wearing her SI brace when you 19 saw her in January of 2014?</p> <p>20 A. Again, I don't recall. I don't 21 remember.</p> <p>22 Q. Did you record that anywhere?</p> <p>23 A. I would have to look at my record. I 24 think that she had one and that she had used it 25 intermittently with some relief of her pain. But I</p>	<p style="text-align: center;">Page 129</p> <p>1 week before.</p> <p>2 A. But my answer goes to whether this 3 related to her mesh-related pain, because she -- 4 even on my exam, she had SI joint pain and 5 tenderness, but it's different than the mesh-related 6 pain that I believe caused her levator spasm.</p> <p>7 Q. You agree that Mrs. Huskey had SI joint 8 pain?</p> <p>9 A. She did.</p> <p>10 Q. Now, my question -- and I'm going to 11 move to strike your earlier answer. I don't think 12 it was responsive.</p> <p>13 My question was this: Did you ask 14 Mrs. Huskey about her compliance in wearing her SI 15 interface in that week before she came to see you 16 and you examined her?</p> <p>17 A. I don't believe I did.</p> <p>18 Q. Do you know what Mrs. Huskey had been 19 doing in the week before you saw her and examined 20 her?</p> <p>21 A. The details of her day-to-day life the 22 week before I saw her, no.</p> <p>23 Q. Do you know if she had had any 24 evaluations or pelvic examinations or procedures 25 before -- in the week before you saw her?</p>

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<p>1 A. I don't know.</p> <p>2 Q. If she had had pelvic examinations in</p> <p>3 the week before you saw her, would that have been of</p> <p>4 interest to you?</p> <p>5 A. No.</p> <p>6 Q. If she had had a pelvic examination and</p> <p>7 a vaginal examination the day before you saw her,</p> <p>8 would that be of interest to you?</p> <p>9 A. It would be helpful to know if she was</p> <p>10 seeing another provider. But I guess I don't know</p> <p>11 what your point is.</p> <p>12 Q. You earlier testified that pelvic and</p> <p>13 vaginal exams of a patient with pain --</p> <p>14 A. Right.</p> <p>15 Q. -- can exacerbate their pain.</p> <p>16 A. But normally those muscles -- you can</p> <p>17 have a woman who has no pelvic floor muscle</p> <p>18 dysfunction, and, while it wouldn't be pleasant,</p> <p>19 probably perform 100 speculum exams on her, and she</p> <p>20 wouldn't have a levator ani spasm.</p> <p>21 So if a person has one exam -- I just</p> <p>22 want to make sure I understand you. Has one exam</p> <p>23 and then comes and presents to another doctor a day</p> <p>24 or two later, a person who would have a normal</p> <p>25 pelvic floor wouldn't be tender. That would not</p>	<p>1 Q. It says, "According to Dr. Pradmudji,</p> <p>2 the levator pain that has occurred since the mesh</p> <p>3 was explanted was precipitated on speculum exam";</p> <p>4 correct?</p> <p>5 A. That is what Dr. Pradmudji said, yes.</p> <p>6 Q. And a speculum examination can cause</p> <p>7 those muscles to go into spasm; right?</p> <p>8 A. Not in someone who did not have pelvic</p> <p>9 floor dysfunction to begin with.</p> <p>10 I've never seen -- the way I interpreted</p> <p>11 this was that someone who had a normal pelvic floor,</p> <p>12 you put a speculum in, I have never seen someone</p> <p>13 have a chronic levator spasm from a speculum exam.</p> <p>14 That's how I interpreted this.</p> <p>15 So I just wanted to clarify. Obviously</p> <p>16 someone who has levator ani pain and you barely</p> <p>17 touch them and you put a speculum in, that's going</p> <p>18 to cause pain and maybe spasm, but not in a person</p> <p>19 who does not have pain and spasm -- a painful</p> <p>20 vagina.</p> <p>21 Q. Did you think that Dr. Pradmudji was</p> <p>22 just talking about a hypothetical patient without</p> <p>23 pelvic floor dysfunction?</p> <p>24 A. I thought she was talking about how --</p> <p>25 the way I interpreted this was that the speculum</p>
<p style="text-align: center;">Page 131</p> <p>1 be -- that exam would still be abnormal. Am I</p> <p>2 making sense?</p> <p>3 Q. I think I understand what you're saying.</p> <p>4 A. Okay. So it would just be -- it would</p> <p>5 just be --</p> <p>6 Q. Mrs. Huskey doesn't have a normal pelvic</p> <p>7 floor; correct?</p> <p>8 A. She doesn't. She has a pelvic floor</p> <p>9 that is hypertonic, painful.</p> <p>10 Q. Right.</p> <p>11 A. She has residual mesh in her pelvis.</p> <p>12 She has inflammatory response. She has levator ani</p> <p>13 spasm. Not normal. Agreed.</p> <p>14 Q. So Mrs. Huskey, if she had seen somebody</p> <p>15 the day before she saw you and had a pelvic and</p> <p>16 vaginal examination, considering she's got pain,</p> <p>17 she's got spasms, that could affect her presentation</p> <p>18 to you the following day?</p> <p>19 A. She may be a little bit more sore, yeah,</p> <p>20 but not a normal patient.</p> <p>21 Q. On the bottom of page number 3, where</p> <p>22 you're talking about the levator spasm --</p> <p>23 A. Which one?</p> <p>24 Q. No. 3.</p> <p>25 A. No. 3, okay. Yes.</p>	<p style="text-align: center;">Page 133</p> <p>1 exam is what caused her to have chronic pelvic pain.</p> <p>2 That's the way I interpreted this, and that is</p> <p>3 incorrect. I've never seen it happen. I've seen</p> <p>4 thousands of women with chronic pelvic pain. I've</p> <p>5 never seen the examination of a normal pelvic floor</p> <p>6 that is not responding to a chronic response, a</p> <p>7 chronic painful response go into a six-month long</p> <p>8 spasm. That's how I interpreted that.</p> <p>9 Q. So it could be that you just</p> <p>10 misinterpreted Dr. Pradmudji then?</p> <p>11 A. Per Dr. Pradmudji, the levator spasm was</p> <p>12 precipitated by a speculum exam. I interpreted that</p> <p>13 as a chronic levator spasm.</p> <p>14 Q. Well, you would agree that the</p> <p>15 levator -- the levator -- strike that.</p> <p>16 You would agree that her levator spasms</p> <p>17 were triggered by the speculum exam? In her, I'm</p> <p>18 talking Mrs. Huskey.</p> <p>19 A. They were worsened by it.</p> <p>20 Q. Okay. You're aware that's in the</p> <p>21 records, the medical records in this case?</p> <p>22 A. That, yeah, when she went to see -- are</p> <p>23 we talking about the event with Dr. Siddique,</p> <p>24 postoperative?</p> <p>25 Q. Okay. For six weeks --</p>

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<p>1 A. But that did not -- but she didn't have 2 anyone touch her pelvis for six weeks. She didn't 3 have vaginal intercourse, because we know she can't 4 still have that. We know she didn't have any 5 additional exertion. So whenever he did go and put 6 a speculum in, it was painful.</p> <p>7 Do I think that's what caused her six 8 months of chronic pelvic pain? I don't. I think 9 they were already tight, and that may have been kind 10 of a -- an additional trigger. But in someone who 11 had a normal pelvic floor, that would not have 12 happened.</p> <p>13 Q. So the insertion of the speculum was 14 what triggered her levator ani spasm; correct?</p> <p>15 A. I don't think so. I think it was tender 16 and it caused a painful response. I've just never 17 seen that happen. In all the thousands of women 18 I've treated, I've never had someone who had a 19 normal pelvic floor and you put a speculum in and 20 they have chronic pain afterwards. I've never seen 21 it.</p> <p>22 Q. Is it your testimony that Mrs. Huskey 23 had a normal pelvic floor at the time this 24 examination was done?</p> <p>25 A. I don't think she does. I don't think</p>	<p>1 the interstitial states. 2 You there?</p> <p>3 A. I am here, yes.</p> <p>4 Q. Did any of Mrs. Huskey's medical records 5 before her sling placement state that she had or may 6 have interstitial cystitis?</p> <p>7 A. She had had some urinary symptoms and 8 chronic urinary tract infections that had resolved. 9 To my knowledge, she had never officially completed 10 a pelvic organ prolapse questionnaire or was seen by 11 a urologist or a urogynecologist who diagnosed her 12 with interstitial cystitis or had any abnormalities 13 on her cystoscopy prior to mesh placement.</p> <p>14 Q. What was the questionnaire you talked 15 about?</p> <p>16 A. It's called a PUF Questionnaire. It's a 17 questionnaire that we use to assess symptoms of 18 interstitial cystitis.</p> <p>19 Q. Can you spell that? Is it P-U-F-F?</p> <p>20 A. P-U -- I think it is P-U -- it's an 21 acronym. I don't know exactly what it stands for. 22 A urologic assessment. It's used routinely in the 23 literature for interstitial cystitis and painful 24 bladder syndrome as diagnostic criteria.</p> <p>25 Q. And did you give Mrs. Huskey this PUF</p>
<p style="text-align: center;">Page 135</p> <p>1 she had a normal pelvic floor after the excision of 2 the -- she didn't have a normal vagina after the 3 mesh was placed. She didn't have a normal pelvic 4 floor after a morbid excision of mesh with residual 5 mesh in her vagina. So I don't think that's a 6 normal pelvic floor.</p> <p>7 Q. At the top of page 4, you're talking in 8 the first paragraph about -- strike that.</p> <p>9 Page 4 in the second paragraph, where 10 we're talking about neuropathic pain.</p> <p>11 A. Yes.</p> <p>12 Q. Okay. Am I correct that when you 13 examined and evaluated Mrs. Huskey, you could not 14 document a single nerve injury?</p> <p>15 A. Meaning I don't think she has a specific 16 nerve injury, necessarily. I also didn't do -- if I 17 was going to try to diagnose a nerve injury, I'd do 18 a diagnostic nerve block, and we did not do that.</p> <p>19 What she did have was generalized 20 sensitivity of the vagina, as well as an abnormal 21 pain response with pinprick sensation.</p> <p>22 Q. But you didn't do any further testing to 23 determine whether it was a nerve injury?</p> <p>24 A. We did not. But her exam was abnormal.</p> <p>25 Q. Section 5, Dr. Pradmodji's opinion about</p>	<p style="text-align: center;">Page 137</p> <p>1 Questionnaire?</p> <p>2 A. I did not.</p> <p>3 Q. And you didn't see one in her medical 4 record?</p> <p>5 A. I didn't, no. But I think that her 6 bladder symptoms are not from primary interstitial 7 cystitis necessarily. I think it's refractory to 8 her mesh procedure, her chronic inflammatory 9 response, scarring, pelvic floor tension. I don't 10 think it just started one day as an interstitial 11 cystitis, even if she did qualify.</p> <p>12 The thing that's difficult with that 13 questionnaire I described is a lot of people will 14 screen positive, even if you don't have the 15 constellation of symptoms that support a diagnosis 16 of interstitial cystitis. So you have to use it 17 with caution because I probably would screen 18 positive, or if we drink too much coffee, we might 19 screen positive to urinary urgency. So it needs to 20 be used in an entire evaluation of the patient, not 21 alone.</p> <p>22 Q. What are the different categories on the 23 PUF Questionnaire that Mrs. Huskey would have likely 24 had positive screenings for besides the urinary 25 tract infections and the urinary symptoms?</p>

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<p>1 A. You know, I'd have to look at it 2 specifically. I mean, I've used it for my research 3 standpoint. It's going to look at how often people 4 void, urgency, pain with voiding. I'm guessing 5 here. I'd have to actually look at the 6 questionnaire.</p> <p>7 Q. Before her sling placement, Mrs. Huskey 8 had pain to her bladder?</p> <p>9 A. She had a short-term episode of 10 suprapubic pain prior to her sling placement.</p> <p>11 Is that the episode you're talking about 12 in November or December of 2012?</p> <p>13 Q. That's the only complaint of pain before 14 the sling?</p> <p>15 A. She had had urinary tract infections 16 that had been treated that were documented in her 17 medical record.</p> <p>18 But as far as six executive months of 19 suprapubic bladder pain that would support a 20 diagnosis of interstitial cystitis, no.</p> <p>21 Q. Interstitial cystitis, that's a clinical 22 diagnosis; correct?</p> <p>23 A. It is. There are also some findings on 24 cystoscopy that occur on patients who have 25 interstitial cystitis, including Hunter's ulcers and</p>	<p>1 well as pain with bladder filling. So if this 2 woman's awake and you're -- she may have pain 3 earlier than a woman who doesn't have interstitial 4 cystitis, as you fill her bladder. You may also 5 have petechiae or inflammation of the lining of the 6 epithelium.</p> <p>7 After you fill it and then release it, 8 you look back in the bladder. That's part of the 9 hydrocystoscopy, hydrodistention that can be 10 performed, looking for small hemorrhages or 11 petechiae that would say that the bladder was kind 12 of stretched beyond its capacity, even if it was at 13 normal volume. So those are other objective 14 findings that we use in addition to their clinical 15 history.</p> <p>16 Q. Do you know what the predictive value of 17 those conditions are then?</p> <p>18 A. Sorry. Can you repeat that? Predictive 19 value?</p> <p>20 Q. Well, so women with -- just so I 21 understand, women with interstitial cystitis, you 22 give them a cystoscopy. Only 10 percent of them are 23 going to have this Hunter's ulcer?</p> <p>24 A. Hunter's ulcers, yes.</p> <p>25 Q. But you don't know the percentage of</p>
<p style="text-align: center;">Page 139</p> <p>1 a small contracted bladder. So low bladder 2 compliance, which you can diagnose on cystoscopy.</p> <p>3 Q. And which percent of patients with 4 interstitial cystitis has the Hunter's ulcer?</p> <p>5 A. 10 percent is the estimated number.</p> <p>6 Q. So that finding in and of itself is not 7 conclusive for interstitial cystitis?</p> <p>8 A. No. But it's really the only 9 reproducible objective finding.</p> <p>10 Q. And that only occurs in about 10 percent 11 of women who have interstitial cystitis?</p> <p>12 A. That's the estimate, yes. I believe she 13 had two normal cystoscopies. After -- or by 14 Dr. Siddique.</p> <p>15 Q. So if a woman has interstitial cystitis 16 because of the prevalence of these ulcers being 17 10 percent on cystoscopy, it's more likely than not 18 those women wouldn't be diagnosed based on the 19 cystoscopic findings?</p> <p>20 MR. KUNTZ: Objection.</p> <p>21 A. Well, there are other findings on 22 cystoscopy that can occur, and I can't give you the 23 exact percentile.</p> <p>24 Q. BY MR. SNELL: Okay.</p> <p>25 A. That would be the low bladder volume, as</p>	<p style="text-align: center;">Page 141</p> <p>1 women who have interstitial cystitis that have these 2 other findings that you just enumerated?</p> <p>3 A. I can't give you a percentile, but I 4 mean -- I can't estimate how many. But there's 5 other things we look for, and that's one of the 6 reasons we use the cystoscopy with hydrodistention.</p> <p>7 Q. A cystoscopy with hydrodistention?</p> <p>8 A. Right. So you fill the bladder. You 9 basically fill the bladder to gravity. You raise a 10 bag of normal saline or whatever you're using to 11 fill the bladder. Approximately 80 centimeters of 12 mercury -- or 80 centimeters squared above the 13 bladder dome. So you just let it backfill. And in 14 normal volume would be -- a gravity greater than 500 15 cc's or so. If you let it backfill to gravity, the 16 normal volume would be 5 to 600 cc's without forcing 17 it to fill. And so in some of these women you'd 18 find a smaller compliance of the bladder. So you 19 wouldn't get that easy going.</p> <p>20 Q. Has Mrs. Huskey ever undergone a 21 cystoscopy with hydrodistention?</p> <p>22 A. Not to my knowledge.</p> <p>23 Q. At the bottom of that page, you talk 24 about the broad symptoms of interstitial cystitis, 25 including suprapubic pain, bladder pain, dysuria,</p>

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<p>1 urgency, frequency, and concurrent urinary tract 2 infections.</p> <p>3 A. Recurrent is probably what I should say.</p> <p>4 Q. Okay. Recurrent. There's a typo. I 5 tried to correct it, but I was wrong.</p> <p>6 A. There is. Into another typo.</p> <p>7 Q. Okay.</p> <p>8 A. That is the constellation of symptoms 9 lasted more than six months.</p> <p>10 Q. The symptoms lasting more than six 11 months, has that -- where is the -- is there a 12 guideline or something that says these have to last 13 more than six months?</p> <p>14 A. It's a chronic pain condition. So I -- 15 I mean, a woman has that with a urinary tract 16 infection that lasts three days. I would not call 17 her having interstitial cystitis. So if a person 18 has persistent chronic pain -- and as we mentioned 19 earlier, my definition of chronic pain is more than 20 six months -- then I would think that they would 21 have symptoms consistent with interstitial cystitis.</p> <p>22 Q. Before having her mesh -- strike that.</p> <p>23 Before the TTVT-O was placed, did 24 Mrs. Huskey have urgency?</p> <p>25 A. She had had some complaints of urgency.</p>	<p>1 interstitial cystitis. That's not the way this 2 disease works.</p> <p>3 Q. Do you know before the placement of the 4 TTVT-O whether she had urgency that hadn't resolved?</p> <p>5 A. I believe she had had a complaint of 6 urgency prior to that. Yes.</p> <p>7 Q. Is it your testimony that that, though, 8 had resolved before her placement of TTVT-O?</p> <p>9 A. No. I think that when she saw 10 Dr. Burkett she did have some urinary urgency.</p> <p>11 Q. What's the difference between urinary 12 urgency and urinary frequency?</p> <p>13 A. The urgency is the feeling that you have 14 to go. Frequency is actually emptying your bladder.</p> <p>15 Q. Going a lot?</p> <p>16 A. Right. But we don't even know 17 necessarily what -- that's not quantified in any of 18 this. Well, if someone feels like they go to the 19 bathroom and they go, technically normal is voiding 20 eight to ten times a day. But someone who voids ten 21 times a day may feel like they're frequent, but 22 that's not quantified, versus someone who voids four 23 times a day and they feel they're fine, and that's 24 probably not healthy, versus someone who always 25 voids at an hourly basis when they're at their</p>
<p style="text-align: center;">Page 143</p> <p>1 But I mean, that intermittent -- I mean, an isolated 2 complaint of urinary urgency is not interstitial 3 cystitis. When we're talking about these chronic 4 pain conditions, it's a clinical diagnosis, and it's 5 something that affects a person's quality of life.</p> <p>6 And I mean, there may be -- I think that 7 what we're doing here is we're taking some of these 8 things out of context and we're trying to apply it 9 to something that is completely different. She may 10 have filled out a review of systems in her doctor's 11 office in 1997 -- and I'm guessing, but I'm just 12 saying anyone could have done this.</p> <p>13 And if they had either a urinary tract 14 infection or too much coffee or they didn't drink 15 enough water, and at that time when you would fill 16 out your review of systems, it's saying, do you a 17 little bit of urgency right now, do you have this.</p> <p>18 That's one of the problems with all of 19 our chronic pain diagnoses is that we are not using 20 a lot of questionnaires or validated questionnaires 21 to help us decide when something was diagnosed, help 22 us differentiate between the different types, help 23 us decide what to treat them with. So an isolated 24 marking on a review of systems 10 years ago saying 25 that she had urgency one time and it resolved, not</p>	<p style="text-align: center;">Page 145</p> <p>1 office because they drink coffee all day. And just 2 because they void 14 times doesn't mean they have 3 interstitial cystitis. That could just be part of 4 their variance.</p> <p>5 I know that Dr. Burkett didn't perform 6 an entire evaluation or offer a questionnaire or do 7 any diagnostic testing for interstitial cystitis 8 before she placed the sling. And what I found and 9 what I heard from the patient was that her urinary 10 symptoms didn't really become problematic until 11 after the excision or the second excision.</p> <p>12 So I mean, I see where you're trying to 13 draw some correlation, but I think that that is 14 incorrect. And that if she does meet a diagnosis of 15 interstitial cystitis now, it's secondary to a 16 morbid surgical procedure from a mesh that was 17 placed years prior.</p> <p>18 Q. So you haven't ruled out interstitial 19 cystitis then; have you?</p> <p>20 A. On Mrs. Huskey, no, I have not. And you 21 mean that just in general or cause of all of her 22 pelvic pain?</p> <p>23 Q. I mean that in general. I mean, you 24 have not ruled out --</p> <p>25 A. No. But --</p>

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<p>1 Q. -- that she doesn't have interstitial 2 cystitis?</p> <p>3 A. Could she? Yeah. Could she from the 4 mesh? Yes. Could she from her intractable spasms 5 of the pelvic floor? Yes.</p> <p>6 That's how all of these systems work 7 together. You get something inflammatory and 8 irritating like a foreign mesh material in someone's 9 pelvis, and then whether or not they might have 10 initiated it -- but I know for sure that the morbid 11 surgery of removing it, which is incredibly 12 difficult and an sensitive procedure, causes 13 significant amount of pain following that attempt.</p> <p>14 Without complete removal of the 15 procedure, foreign body, and leaving her 16 incapacitated, inability to -- inability to use her 17 vagina without pain, inability to have a normal 18 sexual relationship with her husband. And this is 19 what I'm hearing from the patient and what's 20 supported in the medical records. These are the 21 patients I see in my clinic.</p> <p>22 And I don't have a lot of answers for 23 them. It becomes --</p> <p>24 MR. SNELL: Move to strike everything 25 after, "No, but -- could she? Yeah."</p>	<p>1 cause; correct?</p> <p>2 A. I believe that Dr. Pradmudji is a -- I 3 believe she hasn't diagnosed Mrs. Huskey with 4 interstitial cystitis either, technically.</p> <p>5 Q. It's your belief from reading her 6 deposition and her expert report that what she's 7 saying is that interstitial cystitis has not been 8 ruled out in Ms. Huskey's case?</p> <p>9 A. Right. But Mrs. Huskey did not have 10 interstitial cystitis when she had the mesh placed, 11 prior to the mesh placement.</p> <p>12 Q. Prior to having the mesh placed, did any 13 of her doctors rule out interstitial cystitis?</p> <p>14 A. There would be no reason to. She didn't 15 have the profile of interstitial cystitis. She 16 didn't have six months of persistent urinary 17 symptoms that would lead anyone to pursue that 18 pathway with this patient. At least not a pelvic 19 pain expert.</p> <p>20 Q. And you make that statement based upon 21 your review of her records?</p> <p>22 A. And my clinical expertise, yes.</p> <p>23 Q. Did Mrs. Huskey have vaginal atrophy 24 before her TTVT-O placement?</p> <p>25 A. She did.</p>
<p style="text-align: center;">Page 147</p> <p>1 Q. BY MR. SNELL: So Mrs. Huskey may have 2 interstitial cystitis?</p> <p>3 A. And it may be from her mesh.</p> <p>4 Q. I was going to give you that.</p> <p>5 A. But you --</p> <p>6 Q. Well, when I ask a question -- my 7 question before was simple. You haven't ruled it 8 out, and you gave me a long, long answer. That was 9 a yes or no. So we can do this two steps.</p> <p>10 You haven't ruled out interstitial 11 cystitis in Mrs. Huskey's case; correct?</p> <p>12 A. Correct.</p> <p>13 Q. Mrs. Huskey could have interstitial 14 cystitis, but if she does, you would believe that it 15 would be because of her mesh surgery or revisions?</p> <p>16 A. Correct.</p> <p>17 Q. Okay.</p> <p>18 A. And it's because she did not have those 19 symptoms supportive of interstitial cystitis before 20 she had the mesh related procedures, period.</p> <p>21 Q. In your opinion?</p> <p>22 A. In my opinion as a pelvic mesh 23 complication expert, yes.</p> <p>24 Q. And it may just be that you and 25 Dr. Pradmudji disagree on that interstitial cystitis</p>	<p style="text-align: center;">Page 149</p> <p>1 Q. Is that a common finding in 2 post-menopausal women?</p> <p>3 A. It is.</p> <p>4 Q. What is chronic vulvitis?</p> <p>5 A. It's a local inflammatory condition of 6 the vulva.</p> <p>7 Q. What causes that?</p> <p>8 A. Could be a variety of things. Usually 9 it's a local irritant. Dry skin. Too much perfume 10 or lotion on the skin. It's usually easily 11 corrected by removing the irritative factor.</p> <p>12 Q. Did Mrs. Huskey have chronic vulvitis 13 before the TTVT-O?</p> <p>14 A. She did.</p> <p>15 Q. Vaginitis. That's an infection of the 16 vagina?</p> <p>17 A. It's a very common infection of the 18 vagina.</p> <p>19 Q. Is it nonspecific to a particular 20 bacteria or organism?</p> <p>21 A. There are a couple of primary ones that 22 will cause inflammation of the vagina. They're 23 generally, I mean, easy to treat and resolve quickly 24 to treatment.</p> <p>25 Q. Did Mrs. Huskey have vaginitis before</p>

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<p>1 her TVT-O placement?</p> <p>2 A. I believe she was treated prior to her</p> <p>3 procedure, but most women have had at least one</p> <p>4 vaginal infection in their lifetime.</p> <p>5 Q. Vaginitis is different from urinary</p> <p>6 tract infection, or can they be the same?</p> <p>7 A. No. They're different.</p> <p>8 Q. Page 3 and 4 of your report, where you</p> <p>9 say, "According to Dr. Pradmudji, the pelvic exam</p> <p>10 findings are minimal."</p> <p>11 See that?</p> <p>12 A. I do.</p> <p>13 Q. All right. Your exam was done about</p> <p>14 three months before Dr. Pradmudji's exam; correct?</p> <p>15 A. Yes. Exactly.</p> <p>16 Q. Can there be different findings on</p> <p>17 different exams by different doctors where those</p> <p>18 exams are separated by months at a time?</p> <p>19 A. While there can be, as we discussed</p> <p>20 earlier, there can be fluctuation in the patient's</p> <p>21 pain. You also have to know how to assess the</p> <p>22 specific muscles of the pelvic floor, as well as</p> <p>23 attempt to produce the appropriate amount of</p> <p>24 pressure, as well as -- I'll just leave it at that.</p> <p>25 Q. The McGill Pain Questionnaire, that's</p>	<p>1 A. Yes.</p> <p>2 Q. Is that specific to only the posterior</p> <p>3 muscles?</p> <p>4 A. Are you referring to number 1?</p> <p>5 Q. Yes.</p> <p>6 A. And I'm sorry. Can you clarify what</p> <p>7 you're asking?</p> <p>8 Q. When you say, "Posterior muscles will</p> <p>9 react to pain anywhere in the pelvis," my question</p> <p>10 is: Is that relationship only found with the</p> <p>11 posterior muscles or could it be seen with the</p> <p>12 anterior muscles?</p> <p>13 A. No. It's the entire vagina as a whole.</p> <p>14 So the levator --</p> <p>15 Q. So pain from -- okay.</p> <p>16 A. No. It's like the pelvic -- the levator</p> <p>17 complex, the obturator internus, the piriformis. I</p> <p>18 mean, those are what create our pelvic floor</p> <p>19 musculature. So irritation of one of those could</p> <p>20 irritate the other ones, potentially. I mean, the</p> <p>21 vagina is not a very big space.</p> <p>22 Q. Basically the levator spasm,</p> <p>23 Dr. Pradmudji attributes that to other causes other</p> <p>24 than the mesh, but you believe it's from the mesh.</p> <p>25 Is that a fair summary?</p>
<p style="text-align: center;">Page 151</p> <p>1 something you've used in the past?</p> <p>2 A. It is. Yes.</p> <p>3 Q. And that's a questionnaire for assessing</p> <p>4 chronic pain?</p> <p>5 A. It is. We don't have very many. The</p> <p>6 problem with all of our pain questionnaires -- and</p> <p>7 this is consistent throughout the literature -- is</p> <p>8 that they -- even the ones that are designed to</p> <p>9 evaluate chronic pelvic pain and dyspareunia, they</p> <p>10 poorly represent the disease process and do not</p> <p>11 differentiate between the different types of pain.</p> <p>12 So it makes it difficult, as a</p> <p>13 researcher and clinician, to use those regularly</p> <p>14 because it's not specific enough.</p> <p>15 Q. Can that form be helpful in assessing</p> <p>16 chronic pain in a patient?</p> <p>17 A. The only time I would use that form</p> <p>18 would be if I was introducing an intervention and</p> <p>19 was assessing baseline levels and post-baseline</p> <p>20 levels from a research standpoint. But clinically,</p> <p>21 I do not find it helpful.</p> <p>22 Q. Going back to the earlier part of your</p> <p>23 report where you talk about the posterior muscles of</p> <p>24 the vagina will react anywhere in the pelvis.</p> <p>25 We talked about that a little earlier.</p>	<p style="text-align: center;">Page 153</p> <p>1 A. Mesh and excision of the mesh, yes.</p> <p>2 MR. SNELL: Okay. That's all the</p> <p>3 questions I have for you. Thank you for your time.</p> <p>4 I told you I'd get you out of here.</p> <p>5 MR. KUNTZ: I have no questions.</p> <p>6 (Deposition concluded at 2:46 p.m.)</p>

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<p style="text-align: right;">Page 154</p> <p>1 ----- 2 ERRATA 3 ----- 4 PAGE LINE CHANGE 5 ----- 6 REASON: _____ 7 ----- 8 REASON: _____ 9 ----- 10 REASON: _____ 11 ----- 12 REASON: _____ 13 ----- 14 REASON: _____ 15 ----- 16 REASON: _____ 17 ----- 18 REASON: _____ 19 ----- 20 REASON: _____ 21 ----- 22 REASON: _____ 23 ----- 24 REASON: _____ 25 ----- </p>	<p style="text-align: right;">Page 156</p> <p>1 REPORTER'S CERTIFICATE 2 3 I, NAOLA C. VAUGHN, a Certified Court 4 Reporter within and for the States of Missouri and 5 Kansas, hereby certify that the within-named witness 6 was first duly sworn by me to testify to the truth; 7 and that the deposition by said witness was given in 8 response to the questions propounded, as herein set 9 forth; was first taken in machine shorthand by me 10 and afterwards reduced to writing under my direction 11 and supervision; and is a true and correct record of 12 the testimony given by the witness. 13 I further certify that I am not a relative 14 or employee or attorney or counsel of any of the 15 parties, or a relative or employee of such attorneys 16 or counsel, or financially interested in the action. 17 WITNESS my hand and official seal at 18 Tonganoxie, Kansas, this 10th day of July 2014. 19 20 21 22 NAOLA C. VAUGHN, CCR, CRR, RPR 23 Missouri CCR No. 1052 24 Kansas CCR No. 0895 25</p>
<p style="text-align: right;">Page 155</p> <p>1 ACKNOWLEDGMENT OF DEPONENT 2 3 I, _____, do 4 hereby certify that I have read the 5 foregoing pages, and that the same 6 is a correct transcription of the answers 7 given by me to the questions therein 8 propounded, except for the corrections or 9 changes in form or substance, if any, 10 noted in the attached Errata Sheet. 11 12 ERIN T. CAREY, M.D. DATE 13 14 15 Subscribed and sworn 16 to before me this 17 ____ day of _____, 20____. 18 My commission expires: _____ 19 20 Notary Public 21 22 23 24 25</p>	

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